NEURON GENERAL CLAIM FORM

Please complete this form in block capitals using black ink and send your completed claim form and receipts to reimbursementclaims@neuron.ae

neuron

دبـــــي للتـــــأمـــين
DUBAI INSURANCE

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY: SECTION A MUST BE COMPLETED BY THE CLAIMANT, OR BY THE CLAIMANT'S GUARDIAN OR LEGAL REPRESENTATIVE. SECTION B MUST BE COMPLETED BY THE TREATING DOCTOR. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION B IS FULLY COMPLETED BY THE DOCTOR. ALL CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS OF THE DATE OF THE FIRST CONSULTATION.

SECTION A: TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANT'S GUARDIAN OR LEGAL REPRESENTATIVE

Full name of claimant: **Date of birth** (DD/MM/YYYY)**:**

Claimant's Neuron ID: **Sex:** ❑ **Male** ❑ **Female**

Telephone: **Fax:**

Email:

Please state the name and address of your regular doctor or clinic:

Name:

Address:

Telephone: Email:

2. DETAILS OF THE CONDITION BEING TREATED

Please describe your symptoms:

When were you first aware of your symptoms?

When did you first consult a doctor with regard to these symptoms?

What is your doctor's diagnosis?

Have you ever suffered from this or any related condition before? ❑ **YES** ❑ **NO** If YES, when did you suffer from this or the related condition?

Is your claim related to injuries sustained in an accident? ❑ **YES** ❑ **NO**

3. PLEASE LIST THE BILLS FOR WHICH YOU ARE SEEKING REIMBURSEMENT

Please attach the fully itemised accounts including copies of the credit card terminal receipts if you have paid by card. If the total value of your submission is over AED1,000, you must submit the originals to Neuron by post.

Date(s) of treatment:	Details of the bills you have enclosed for reimbursement:	Please state currency and amount paid:

4. ACCOUNT DETAILS FOR REIMBURSEMENT

❑ **PAYMENT TO YOUR BANK ACCOUNT**

Currency in which you would like to be reimbursed:

If you have previously submitted a claim, are your payment details the same? ❑ **YES** ❑ **NO** ❑ **NOT APPLICABLE**

If YES, please confirm the last 4 digits of your account number: and then go to part 5.

If NO, please provide your account details below:

Bank name and address:

Account holder name(s):

IBAN number*: BIC Number*:

* BIC and IBAN details are necessary for all transfers to European and UAE bank accounts.

❑ **PAYMENT BY CHEQUE** **NB. Payment can only be made in UAE Dirhams.**

Payee Name

5. DECLARATION AND AUTHORISATION

Do you have any other insurance cover?

❑ No, I have no other health insurance cover ❑ Yes, I have other health insurance cover with: _____

I hereby give Neuron LLC authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition/s and financial payment information. I also authorise any doctor of medicine, hospital or other health professional who has attended or examined me, to furnish Neuron LLC and/or their authorised representative any and all information with respect to illness, medical history, consultation, prescription, medical investigations or treatment and copies of all hospital records and/ or medical records.

Name of claimant:

Date of birth (DD/MM/YYYY):

Signature of claimant (or guardian): **Date:**

SECTION B: TO BE COMPLETED BY THE CLAIMANT'S DOCTOR

1. PATIENT DETAILS

Patient's full name: **Sex: ❑ Male ❑ Female**

Date of birth (DD/MM/YYYY)**:**

Was the patient referred to you? ❑ YES ❑ NO If YES, please state the name and contact details of the referring doctor:

2. DATES

1. Please confirm the date the patient first registered at your facility (DD/MM/YYYY)**:**

2. On which date did the patient first consult you for this particular condition (DD/MM/YYYY)**?**

3. Please give a short description of your patien's symptoms or injuries, if they have suffered an accident:

4. In your professional opinion, on what date would the patient have been aware of their symptoms? (DD/MM/YYYY)

5. Has your patient previously suffered from this or from any related condition? ❑ YES ❑ NO

If YES, please give full details of the previous condition/related condition, and the dates on which it first occurred:

3. YOUR DIAGNOSIS

What is your clinical diagnosis?

4. YOUR TREATMENT PLAN

Please provide a treatment plan including details of test performed and medications currently being prescribed to the patient:

6. DECLARATION BY DOCTOR

I declare that I am the patient's treating doctor, and that the particulars given above are, to the best of my knowledge, full, true and complete.

Signature: **Date** (DD/MM/YYYY)**:**

Print your name and address:

Telephone: **Fax:**

Email:

دبـــــي للتـــــأمـــين
DUBAI INSURANCE

Neuron LLC
I.T Plaza Building, 6th Floor,
Dubai Silicon Oasis,
PO Box 72071, Dubai,
UAE
reimbursement@neuron.ae
www.neuron.ae

WilliamRussell
Expatriate Insurance Specialists

Plans designed by William Russell Ltd