Dear Member,

Please make sure all sections of the form are filled. In case of any assistance please contact the Neuron toll-free helpline at the below numbers:

Within UAE: 800-4408
Outside UAE: +9714-3178500

The completed claim form should be returned back to Neuron along with all necessary documents applicable, as indicated below:

- **Copy of radiology/imaging reports, blood test results, other reports for special/diagnostic procedures etc. (where you have paid and are claiming for radiology/x-rays, imaging procedures e.g. Ultrasound, CT and/or MRI Scans, blood tests, etc.)**
- **Copy of the prescription/s (where you have paid and are claiming for medications)**
- **Discharge summary and medical report (in case you are claiming In-Hospital patient admissions).**
- **In case of surgical procedure, please attach operative notes, anesthesia sheets, and all histopathology reports.**
- **All invoices (with proper and detailed breakdown of amounts) and receipts (clearly showing that cash/credit card payment has been made by you).**
- **ANY MISSING INFORMATION MAY LEAD TO REJECTION.**

Please fill the details below:

Details of member / patient:

Name of Patient:	**Contact Number:**
Emirates I.D.:	**Email address:**
Neuron ID:	**Date of Birth:**
Name of Principal Member:	**Relationship to Principal member:**

Payment Details:

Please choose payment type:	**Bank Transfer** ☐								**Cheque*** ☐														
1. Bank Transfer – (Please complete all details to enable bank transfer payments)																							
Account/Payer Name:																			**Payment Amount/Currency:**				
Bank Name:																			**Bank Address:**				
Swift Code:																			**Account Number:**				
IBAN Number:	|	|	|	|	|	|	|	|	|	|	|	|	|	|	|	|	|	|	|	|	|

*Please mention Beneficiary Name

Is this claim due to accident/injury? Yes ☐ **No** ☐ **If yes, include medical information.**
Date of accident/injury (dd/mm/yyyy) ____/____/_____
Have you obtained a prior approval for the requested services? Yes ☐ **No** ☐

Details of Medical Condition: (To be filled in by the treating physician)

Date of Visit: _____/____/_____
Medical Condition requiring treatment:
Please provide the preliminary and final diagnosis with a brief summary of the case management:

Date of onset of symptoms: _____/_____/_____
Date of first consultation related to the above case: _____/____/

I declare that I am the patient's treating Physician, and that the particulars given are to the best of my knowledge true and correct

Name of treating Doctor:	**Telephone:**
Address of treating doctor / clinic: (please include city and country)	**Signature of Treating doctor with Stamp:** **Date: / /**

Member's declaration: (To be signed by the member or in case of minor by the principal member / guardian)

I confirm I am the patient (or the patient's parent or guardian if the patient is under 16 years of age) and wish to claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. In respect of any medical claim. I hereby consent to and authorize the medical practitioner, health professional or other relevant medical establishment to provide and discuss any health/treatment details, medical records or discharge arrangements (past and present) with and to the Insurer and/or Third Party Administrator representative. I agree that a copy of this consent shall have the validity of the original.	**Name & Signature of the Member / Principal Member / Guardian** _____ **Date: _____/____/_____**

The claim form should be submitted within 90 days of start date of the treatment along with all original receipts/invoices as per the policy membership agreement. Claims will not be considered if not submitted within 90 days of treatment being received.

For Neuron Internal Use only:

Received Date:	**Claim I.D. No.:**

REIMBURSEMENT CLAIMS
REQUIREMENTS CHECK LIST

DESCRIPTION	PROVIDED		COMMENTS
Completed neuron claim form	☐ YES	☐ NO	
Patient's detail (name, neuron id, signature)	☐ YES	☐ NO	
Diagnosis , treatment and history	☐ YES	☐ NO	
Doctor's signature & stamp/clinic stamp	☐ YES	☐ NO	
Original clinic invoices with proper breakdown of treatment costs and or, medications given with corresponding costs.	☐ YES	☐ NO	
Pathology results/radiology results/laboratory results (if done)	☐ YES	☐ NO	
Medical report and, or discharge summary (incase patient was admitted in the hospital)	☐ YES	☐ NO	
Original prescription for medicines and corresponding receipts/invoice/proof of payment	☐ YES	☐ NO	
Original pharmacy invoices/receipts with paid stamp with proper breakdown of costs	YES	☐ NO	
ENGLISH/ARABIC TRANSLATION OF DOCUMENTS IF WRITTEN IN FOREIGN LANGUAGE (If treatment done was outside UAE) *This can be requested from the hospital/clinic prior to issuance of the documents	YES ☐	NO ☐	
Annual leave details (from hr) once treatment done was on annual leave	☐ YES	☐ NO	