CLAIM FORM

IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM OR ANY OTHER ASPECTS OF YOUR COVER, PLEASE CALL NEURON LLC ON 800 44 08

DETAILS OF POLICY HOLDER/PATIENT:		
Policy Holder´s Name	Date of Birth	Date received (Neuron use only)
Patient´s Name and Address	Tel Number Fax Number	
Email Address	Claim Number	
Patient´s Relationship to Member	Membership Number from your card	

MEDICAL SECTION (To be fully completed by patient´s medical practitioner - all boxes must be completed in block capitals)	
Medical Practitioner´s Name and Address	Date symptoms first noticed by patient Tel Number Fax Number
I declare that I am the patient´s practitioner, and that the particulars given are to be the best of my knowledge true and correct. Signature Date	Medical Practitioner´s Stamp
Medical Condition requiring treatment	
Please give the date on which your patient first presented to any doctor for this condition	
Please give a full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates. Please also advise any further treatment planned.	

OTHER INSURER´S DETAILS (If the treatment is accident-related or covered under another insurance policy please provide name of insurance company)

PATIENT´S DECLARATION AND CONSENT	
I confirm that I am the patient/patient´s parent or guardian (if patient 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. I hereby consent to and authorize the medical practitioner involved in the patient´s care to discuss treatment details and discharge arrangements with and to ESDB and Neuron. I agree that a copy of this consent shall have the validity of the original.	Signature Date

The claim form must be submitted within 90 days from start date of the treament along with all original receipts/invoices - as per the policy agreement. Claims will not be considered if not submitted within 90 days of treatment being received. Missing documents must be resubmitted within 30 days from date request for missing documents has been sent. Send this claim form together with supporting material to:

MEDICAL CLAIMS DEPARTMENT, EXPAT SERVICES GMBH, PO BOX 112354, DUBAI, UAE

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