Reimbursement Form (Medical Part)

Please Use **BLOCK** letters to fill this form, and ensure that all sections are completed.

Section 1 - Member Information

Patient name (as printed on card)		
Patient card number		DOB
Principal name (as printed on)		
Principal contact information	E-mail:	Mobile

Section 2 - Medical Information

(To be fully completed by patient's medical practitioner - all boxes must be completed in BLOCK letters.)

Country of treatment	Provider name and contact information
Date when first symptoms were noticed	Physician name and contact information
I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.	Physician signature and official stamp Date / /

Please provide details of diagnosis (primary and secondary) or symptom(s) and prescribed treatment(s) or investigation(s).

Symptoms:

Diagnosis:

Treatment / investigation:

Patient name	Card number

Reimbursement Form (Financial Part)

Section 3 - Claimed Invoices

No.	Invoice number	Claimed amount	Currency	No.	Invoice number	Claimed amount	Currency
Total claimed amount per currency:							

Section 4 - Settlement (Kindly ensure bank details are in print form)

Settlement currency:	Settlement by: ☐ Wire Transfer
(A) Bank name	(B) Account holder name
(C) IBAN number / Account number	(D) SWIFT code
(E) Bank address	(F) Beneficiary address

Important Notes:

- Please submit the medical reports from your treating physician, pharmacy prescriptions, investigations requests and their results, invoices with itemized breakdown and original receipts. In case of online submission, please retain the original documents as they may be required to finalize your claim.
- Neuron prior approval is required for all non-emergency hospitalizations. Before admission, you are kindly required to e-mail a detailed medical report and cost estimate of the proposed treatment on official letterhead duly signed and stamped by the treating physician to reimb.approval@neuron.ae
- For your convenience, bank account details can be saved and available for editing on your profile page on myNeuron portal https://myneuron.neuron.ae/
- Alternatively, for transfers within the U.A.E., fields (A), (B) and (C) in this form are mandatory. For transfers outside the U.A.E., please complete all fields in the settlement section above. In case IBAN is not available in the destination country please enter bank account number in lieu of IBAN number. Please note that transfers outside the U.A.E. are subject to charges that may be applied by your bank.
- Neuron bears no liability for any incorrect bank account details provided above. Furthermore, any charges related to corrective action shall be deducted from the final settlement.
- All Documents must be submitted in English or Arabic, documents in other languages must be translated prior to submission.
- Claims submissions and resubmissions timelines are subject to policy terms and conditions.

I, the undersigned, confirm that I am the patient/patient's spouse or guardian (if patient is under 18 years of age) and I wish to claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. In addition, I authorize and request any hospital, physician, and any other health provider to furnish Neuron LLC with the complete information including copies of their records in connection with medical treatment and/ or other services provided to me or to my dependent. I also agree that a copy of this consent shall have the validity of the original.	Signature of the principal and or spouse Date: / / 20

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 with speciality and license number and hospital/clinic stamp	☐ Yes	☐ No	
Original hospital/ clinic invoices with proper breakdown of treatment costs and or, medications given with corresponding costs.	☐ Yes	☐ No	
Pathology / radiology / laboratory / Investigational official results (if done)	☐ Yes	☐ No	
Detailed medical report (onset & history of the condition and conservative treatments done) and, or discharge summary (in case patient was admitted)	☐ Yes	☐ No	
Original and recent medicine prescription and optical prescription (if done)	☐ Yes	☐ No	
Original pharmacy invoices/receipts with paid stamp with proper breakdown of costs	☐ Yes	☐ No	
Referal letter from a specialist with treatment plan (e.g. Physiotherapy, Psychotherapy)	☐ 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	