

Section 1 - Provider Name and Code (to be completed by provider's personnel)

Provider Name	Provider Code
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Section 2 - Member's Details (to be completed by provider's personnel)

Membership No.			
Member's Name (as it appears on the Neuron card)			
Date of Birth		Gender	☐ Male ☐ Female
Telephone No.			

Section 3 - Service Information (to be completed by treating optician)

Diagnosis		
Optical Aids Advised		Cost
	A. A pair of single vision lenses	
	B. A pair of bifocal vision lenses	
	C. A pair of tri-focal vision lenses	
	D. A pair of contact lenses	
	E. Other (specify)	

Section 4 - Optician's Declaration (Optician to affix signature on this section along with date)

I declare that I am the member's optician, and that the particulars given are to the best of my knowledge true and correct. Signature _____ Date _____	Stamp of the optics store
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Section 5 - Patient's Declaration (patient to affix signature on this section along with date)

I confirm I am the patient (or the patient's parent or guardian if the patient is under 16 years of age) and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorise the medical provider, 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. I agree that a copy of this consent shall have the validity of the original.	
Signature _____	Date _____

Section 6 - Preauthorization Details

Approval code	
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Section 7 - Other Insurer's details (if the treatment is accident - related or covered under another insurance policy please provide details)

Insurance company name	Policy number
Completed claim form along with supporting documents should be submitted to Neuron within the stipulated time-frame for submissions to be considered for payment as per relevant terms and conditions.	