ADNIC

شركة أبوظبي الوطنية للتأمين
ABU DHABI NATIONAL INSURANCE COMPANY

DIRECT BILLING CLAIM FORM

Please read the instructions & guidelines on overleaf before filling the form

Voucher No.:

Patient's name: Patients Health Card no.:

Employer's Name

Principal member's name

If Patient is not the Principal Member, tick relationship

SPOUSE

☐

CHILDREN

☐

EID NO.

DATE OF BIRTH/ GENDER

Medical information: (To be filled by treating doctor for all outpatient treatment. For cases like hospitalization procedures and surgeries, a detailed medical report is required)

Condition requiring treatment (**Chief Complaints**):

DIAGNOSIS:

CONSERVATIVE:

Visit date:

Reason for visit or Type of treatment availed:

Emergency, IP,OP, Optical, Maternity, Dental etc;

Onset and duration of illness:

Underlying conditions:

Clinical Findings:

Treatment details:

I declare that I have attended to this patient and that the particulars given are to the best of my knowledge true and correct.

Name & signature of the doctor: .....

Date: ..... Stamp: .....

Name & Address of the Hospital/Clinic	Bill No.	Treatment Date	Description of Services	Amount
			TOTAL	