Adnic Claim Form

ADNIC MEDICAL INSURANCE SCHEME **INSURANCE COPY**

CLAIM FORM - DIRECT BILLING

Patient's Membership No.INS123455
Group Member's Name (Mr./Mrs./Miss):
fgfg
Patient's Name (if not Group Member)
Tahaseen Tahaseen
Patient's Contact No./Mobile
(Mandatory)
971508679321

Voucher No.:44
Employer's Name
fgvfg
Patient's date of birth
2001-09-09

If Patient is not the Group Member, tick relationship ○ Wife ○ Husband ○ Child

For an in-patient stay in hospital Admission Date Discharge Date

Please enter date(s) of admission and discharge 2023-11-29 2023-11-29

Is the cost of this treatment also covered by any other insurer? (Mandatory) ○ Yes ○ No

Was the treatment necessary as the result of an accident? ○ Yes ○ No

If the answer to either question is YES, please give full details.
fdgfg

I hereby claim for costs of treatment and declare that, to the best of my knowledge and belief, all information given in support of this claim is true and complete.

Member's Signature

Date:2023-11-29

PART 2
To be completed by Doctor/Specialist who carried out the treatment
Please complete this form in BLOCK CAPITALS

Condition requiring treatment fdgfdg

Details of treatment / operation / on set of illness fdgfdg

Name(s), qualification and address(es)/License No. of Doctor / Specialist / Provider License No.Doctor Vision

Date:2023-11-29