# Adnic Claim Form

| ADNIC MEDICAL INSURANCE SCHEME | INSURANCE COPY |
|---|---|

**CLAIM FORM - DIRECT BILLING**

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**PART 1**

COMPLETE PART 1 OF THIS FORM.

Part 2 must be completed by the doctor / specialist giving details of treatment received.

Submit this form with original account(s) within 45 days of the expenditure beingin curred.

Your claim will not be considered if not submitted within the above Period.A NEW CLAIM FORM IS REQUIRED EACH TIME YOU SUBMIT ACCOUNTS.

◉ Yes
○ No ○ Yes
○ No

| | | |
|---|---|---|
| Patient's Membership No.25786785 | Voucher No.:44 | |
| Group Member's Name (Mr./Mrs./Miss): | Employer's Name | |
| ggg | ggg | |
| Patient's Name (if not Group Member) | Patient's date of birth | |
| tausif bamne | 1998-02-09 | |
| Patient's Contact No./Mobile (Mandatory) | | |
| 971525169449 | | |
| For an in-patient stay in hospital | Admission Date | Discharge Date |
| Please enter date(s) of admission and discharge | 2023-02-06 | 2023-02-06 |

If the answer to either question is YES, please give full details.
ghvft
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:2023-02-06**

PART 2

Condition requiring treatment ghvb

To be completed by Doctor/Specialist who carried out the treatment

**Details of treatment / operation / on set of illness hgyctvf**

Please complete this form in BLOCK CAPITALS

Name(s), qualification and address(es)/License No. of Doctor / Specialist / Provider License No.Doctor44

**Date:2023-02-06**