

# REIMBURSEMENT MEDICAL CLAIM FORM

Voucher No :55

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

## 1. Patient Details

Patient's Name:	Aswathi Vipin	Patient Health Card No:	pls1234567
Group Member's Name:	gtfdrgt	Type of Plan:	ADNIC
Employer's Name:	Alan Alfred	Telephone No:	971522058818
Email ID:	aswathibdk@gmail.com	Address:	Date of Birth: 1991-11-21

## 3. Medical Information(To be filled by treating doctor for all outpatient for cases like hospitalization procedures surgeries-detailed medical report is required)

Condition Requiring treatmentfgfdg Visit Datefgdgdg

Onset and duration of illness:

fgfdg

## Treatment Details

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


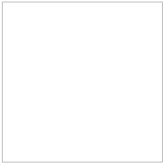
Name & Signature of the Doctor:

Stamp :

Date:2023-11-27

This form will acknowledge your consent to treatment recommended by your Dental Implantologist

Sign here, only if all of your questions have been answered to your satisfaction

PATIENT	WITNESS	DOCTOR
		
If Guardian, relation to the Patient		