Adnic Claim Form

ADNIC MEDICAL INSURANCE SCHEME | **INSURANCE COPY**

CLAIM FORM - DIRECT BILLING

Patient's Membership No.INS12345
Group Member's Name (Mr./Mrs./Miss):
fgfh
Patient's Name (if not Group Member)
tousif toplife
Patient's Contact No./Mobile (Mandatory)
971563687976

Voucher No.:33
Employer's Name
fdgvfg
Patient's date of birth
2021-06-16

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.dfghbfhI 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 fdh

Details of treatment / operation / on set of illness dfhh

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

Date:2023-11-29