Adnic Claim Form

ADNIC MEDICAL INSURANCE SCHEME | **INSURANCE COPY**

CLAIM FORM - DIRECT BILLING

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.

Patient's Membership No.INS1234567	Voucher No.:55
Group Member's Name (Mr./Mrs./Miss):	Employer's Name
jjjj	yhyh
Patient's Name (if not Group Member)	Patient's date of birth
Vision Test Patient	2020-06-17
Patient's Contact No./Mobile (Mandatory) 971569874589	
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	2023-11-28 / 2023-11-28
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.

gg

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:2023-11-28

PART 2

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

Please complete this form in BLOCK CAPITALS

Condition requiring treatment yghg

Details of treatment / operation / on set of illness fff

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

Date:2023-11-28