

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 being incurred.

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. 8762564658746

Group Member's Name (Mr./Mrs./Miss):

ww

Patient's Name (if not Group Member)

bnmn fghj

Patient's Contact No./Mobile (Mandatory)

9715487515700

For an in-patient stay in hospital

Please enter date(s) of admission and discharge

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

ww

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



Voucher

No.: 11

Employer's

Name

ww

Patient's

date of birth

1900-01-01

Admission

Date

2023-09-09

Discharge

Date

2023-09-09

Date: 2023-09-09

PART 2

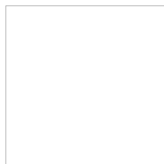
Condition requiring treatment ww

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

Details of treatment / operation / on set of illness ww

Please complete this form in BLOCK CAPITALS

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



Date: 2023-09-09