Medical Expenses Claim Form

Date	:	2024-03-13	Clinic Name	:	VISION MEDICAL & DENTAL CENTER (Abu Dhabi)	Emirates ID	:	784-1996-9294842-7
Card Holder's Name	:	sandhya rani	Age	:	0	Gender	:	Female
Mobile No	:	971587654201	Ins Card No	:	INS12345	Valid Upto	:	2023-11-29
Company Name	:	ADNIC	Employee No	:	1	Nationality	:	Other

Clinical Details

Signs & Symptoms

Date of Onset Illness : 4/23/2024 12:00:00 AM

○ Emergency ○ Work related ○ New visit ○ Follow up visit

Diagnosis : NA

Management plan (Services inside the clinic including injections and investigations) NA

test test - Laser (1)
Doctor Name

Signature & Stamp

Diagnostic Procedures referred outside

sandhya

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the above-mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Patient's Signature
2024-03-13

Date

Pharmaceuticals (to be filled by treating doctor only)