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.INS12345678	Voucher No.:66
Group Member's Name (Mr./Mrs./Miss):	Employer's Name
ghgh	ghfh
Patient's Name (if not Group Member)	Patient's date of birth
Reshma Siya	1995-05-21
Patient's Contact No./Mobile (Mandatory) 971522058819	
If Patient is not the Group Member, tick relationship	◉ ○ ○

For an in-patient stay in hospital — Admission Date — Discharge Date

Is the cost of this treatment also covered by any other insurer? (Mandatory) ○ ◉

Was the treatment necessary as the result of an accident? ○ ○

Please enter date(s) of admission and discharge

2023-11-28

2023-11-28

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

ghgh

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

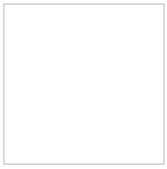
To be completed by Doctor/Specialist who carried out the treatment

Please complete this form in BLOCK CAPITALS

Condition requiring treatment gfhgfh

Details of treatment / operation / on set of illness ghfgh

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



Date:2023-11-28