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.:44

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

Employer's Name

FGFG

FDDG

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

(•) If Patient is not the Group Member, tick relationship

Was the treatment necessary as the result of an accident?

For an in-patient stay in hospital

Admission Date	Discharge Date
2023-11-27	2023-11-27

Please enter date(s) of admission and discharge

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

DFGF

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:2023-11-27

PART 2

Condition requiring treatment FDGFG

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

Details of treatment / operation / on set of illness FGFG

Please complete this form in BLOCK CAPITALS

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

Date:2023-11-27