



ADNIC MEDICAL INSURANCE SCHEME		INSURANCE COPY	
CLAIM FORM - DIRECT BILLING			

PART 1		Patient's Membership No.INS12345		Voucher No.:44
COMPLETE PART 1 OF THIS FORM.		Group Member's Name (Mr./Mrs./Miss):		Employer's Name
Part 2 must be completed by the doctor / specialist giving details of treatment received.		fgfrg		rgtfg
Submit this form with original account(s) within 45 days of the expenditure being incurred.		Patient's Name (if not Group Member)		Patient's date of birth
Your claim will not be considered if not submitted within the above Period.A NEW CLAIM FORM IS REQUIRED EACH TIME YOU SUBMIT ACCOUNTS.		Reshma Siya		1995-05-21
		Patient's Contact No./Mobile (Mandatory)		
		971522058819		
		If Patient is not the Group Member, tick relationship		<input checked="" type="radio"/> Wife <input type="radio"/> Husband <input type="radio"/> Child
		For an in-patient stay in hospital		Admission Date Discharge Date
		Please enter date(s) of admission and discharge		2023-11-27 2023-11-27
		Is the cost of this treatment also covered by any other insurer? (Mandatory)		<input type="radio"/> Yes <input checked="" type="radio"/> No
		Was the treatment necessary as the result of an accident?		<input checked="" type="radio"/> Yes <input type="radio"/> No

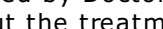
If the answer to either question is YES, please give full details.

fgf

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 To be completed by Doctor/Specialist who carried out the treatment Please complete this form in BLOCK CAPITALS	Condition requiring treatment fgfh
	Details of treatment / operation / on set of illness fggh Name(s), qualification and address(es)/License No. of Doctor / Specialist / Provider License No. Doctor Vision