


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.INS1234567	Voucher No.:33	
	Group Member's Name (Mr./Mrs./Miss):	Employer's Name	
	ggg	ggg	
	Patient's Name (if not Group Member)	Patient's date of birth	
	Aswathi Vipin	1991-11-21	
	Patient's Contact No./Mobile (Mandatory)		
	971522058818		
	<input type="radio"/> If Patient is not the Group Member, tick relationship		
	<input checked="" type="radio"/> 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	
Please enter date(s) of admission and discharge	2023-11-27	2023-11-27	
If the answer to either question is YES, please give full details.			
ggg			
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 ggg

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

Details of treatment / operation / on set of illness ggg

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