ADNIC

شـركـة أبـوظـبـي الوطـنـيـة للتأمين

ABU DHABI NATIONAL INSURANCE COMPANY

INCORPORATED IN ABU DHABI IN 1972 – PAID UP CAPITAL DHS. 375,000,000, SUBJECT TO THE PROVISIONS OF FEDERAL LAW No. (9) OF 1984 REGISTRATION NO. (1) DATED 22-07-1984

	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. **618408-1-A**

Voucher No.:

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

Employer's Name

Patient's Name (if not Group Member)

Patient's date of birth

AHMED ABDELREHEEM MUHMOUD

Patient's Contact No./Mobile (Mandatory)

0553162777

If Patient is not the Group Member, tick relationship

Wife ☐ Husband ☐ Child ☐

For an in-patient stay in hospital	Admission Date	Discharge Date
Please enter date(s) of admission and discharge	**13-Aug-2025**	**13-Aug-2025**

Is the cost of this treatment also covered by any other insurer? (Mandatory) YES ☐ NO ☐

Was the treatment necessary as the result of an accident? YES ☐ NO ☐

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

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 13-Aug-2025

PART 2

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

Please complete this form in BLOCK CAPITALS

Condition requiring treatment

came with investigations:

calcium low

vitamin D low

mucus in the urine

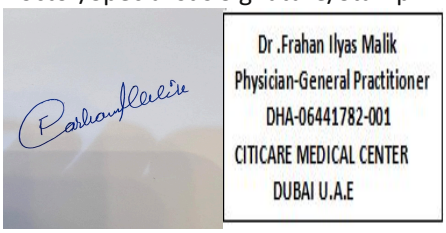
Details of treatment / operation / on set of illness

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

Dr.Farhan Iyas

Home Visit Hospital Call	Specialist Consultation	Medication / Injection	Lab/X-Ray	Out-Patient Procedure	Dental (Attached)	Materinity	Hospital A/c (attached)	Physiotherapy	TOTAL CHARGES

Doctor/Specialist's Signature/Stamp



Date:**13-Aug-2025**
