



INAYAH TPA (L.L.C)

Request for Cashless Hospitalization / Direct Billing for Medical Insurance Policy

Details of the Third Party Administrator

Name of TPA/ Insurance Company:	INAYAH TPA (L.L.C)
Toll Free/Phone Number:	800-462924 / +971 4 3552354
Fax:	+971 4 3512339

To be filled by the Insured / Patient

Name of the Patient:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age: Years Months	Contact Number:	
INAYAH ID Card Number:		Policy Number/Corporate:	
Employee ID:	Currently do you have any other Medclaim/ Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		
Company Name / Details:			
Policy No:	Sum Insured:		
Name of the Family Physician:		Contact Number:	

To be Filled by the Treating Doctor / Hospital

Name of the Treating Doctor:		Contact Number:
Nature of illness/ Disease with presenting complaints:		
Relevant Clinical Finding:		
Duration of the Present Ailment:	Date of First Consultation: / /	
Past history of Present Ailment,if any:		
Provisional Diagnosis:		ICD 10 Code:
Proposed Line of Treatment: <input type="checkbox"/> Medical Management <input type="checkbox"/> Surgical Management <input type="checkbox"/> Intensive Care <input type="checkbox"/> Investigation <input type="checkbox"/> Non Allopathic Treatment		
If Investigation & Medical Management, Provide details:		
Route of Drug Administration:		
If Surgical, Name of Surgery:		ICD 10 PCS Code:
If other treatments provide details:		How did this injury occur:
In case of Accidents: Is it RTA? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury: / /	Reported to Police? <input type="checkbox"/> Yes <input type="checkbox"/> No
Injury/ Disease caused due to substance abuse/ alcohol consumption? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Test conducted to establish this? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, attach reports)	In case of Maternity: <input type="checkbox"/> G <input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> A	
LMP:		

Detail(s) of Patient Admitted:

Date of Admission: / / Time: :
Is this an Emergency/Planned Hospitalization?
Expected No. of days of stay in Hospital: Days
Room Type/Category:
Per Day Room Rent + Nursing and Service Charges + Patient's Diet: AED.
Expected cost for Investigation + Diagnostics: AED.
ICU charges: AED.

Mandatory: Past History of any chronic illness

	if yes since (month/year)
<input type="checkbox"/> Diabetes Mellitus	____/____
<input type="checkbox"/> Heart Disease	____/____
<input type="checkbox"/> Hypertension	____/____
<input type="checkbox"/> Hyperlipidemias	____/____
<input type="checkbox"/> Osteoarthritis	____/____
<input type="checkbox"/> Asthma/ COPD/ Bronchitis	____/____
<input type="checkbox"/> Cancer, Tumor, Cyst or growth of any kind	____/____
<input type="checkbox"/> Alcohol or drug abuse	____/____

OT charges: AED.	<input type="checkbox"/> Any HIV or STD/ Related Ailments _____/____
Professional Fee(Surgeon) + Anaesthetists Fee+ Consultation Charges: AED.	<input type="checkbox"/> Epilepsy or Tuberculosis _____/____
Medicines + Consumables+ Cost of Implants (if Applicable please specify). Other Hospital Expenses if any: AED.	<input type="checkbox"/> Any Physical Disability or Disease of Eye _____/____
All Inclusive package charges applicable,if any: AED.	<input type="checkbox"/> Depression, Mental or psychiatric condition _____/____
Probable Date of Admission : / /	<input type="checkbox"/> Disorder of bones, joints or muscles _____/____
Less than 24 Hours: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Stroke, Anemia, any Blood Disorder, Chest Pain, elevated cholesterol, disorder of kidney or genitor- urinary system, liver disorder, hepatitis (including hepatitis B carrier) _____/____
Sum Total Expected Cost of Hospitalization: AED.	<input type="checkbox"/> Any disease or Disorder of Brain & Nervous System, Respiratory system, Digestive System or Circulatory system. _____/____
	<input type="checkbox"/> At any stage during the past 5 years, have you either been prescribed medication (other than for cold or flu) or received medical treatment/ advice on a regular basis _____/____
	<input type="checkbox"/> Any other ailment give details: _____/____

Medical Plan (Itemized Orginal Invoices and Applicable Prescriptions/ Reports/ Results must be enclosed to consider claim)			
Pharmacy	Estimated Cost	Laboratory/ Radiology	Estimated Cost

Hospital Declaration:

- 1) We have no objection to any authorized official documents pertaining to insured's hospitalization.
- 2) All valid original documents countersigned by the insured to be dispatched to INAYAH TPA (L.L.C), Dubai office within 7 days of the patients' discharge.
- 3) All non-medical expenses and expenses not relevant to the hospitalization or illness which is not payable by INAYAH TPA (L.L.C) to be collected from the patient.
- 4) INAYAH TPA (L.L.C) will not be liable to make the payment in the event of any discrepancy between the facts presented at the time of submission of final documentation and pre-authorization request.
- 5) The patient declaration has been signed by the patient or his representative in our presence.

Patient's Declaration:

- 1) I agree to allow the hospital to submit all original documents pertaining to the hospitalization to INAYAH TPA (L.L.C) after discharge.
- 2) In case INAYAH TPA (L.L.C) is not liable to settle the hospital bill to discrepancy in documentation, I take complete responsibility to settle the bill.
- 3) All non-medical expenses, expenses not relevant to the present hospitalization amount, over and above the limit authorized by INAYAH TPA (L.L.C) will be paid by me.
- 4) I hereby declare to abide by the rules and regulations of the policy and if at any time the facts disclosed by me are found to be false or incorrect. I forfeit my right to the claim.
- 5) I agree and understand that INAYAH TPA (L.L.C) is in no way warranting the services provided by the hospital to be of a particularity or standards.
- 6) I hereby warrant the truth of the foregoing particulars in every respect and I agree that if have made or shall make any false or untrue statement, suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that in respect of the above treatment no benefits are admissible under any other medical scheme or insurance.

Provider's Seal Treating Doctor's Signature Patient/Insured Signature Patient/ Insured Name