INAYAH TPA (L.L.C)

Pre -Authorization / Direct Bi

# 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: SAAD ASEEM HUSSEIN

Gender: (●) Male ( ) Female Age:15Y - 9M - 18D Contact Number: 0547864379

INAYAH ID Card Number: 6H57-B-ELBR-G24 Policy Number/Corporate:

Currently do you have any other Mediclaim/ Health Insurance ( ) Yes ( ) 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: Enomen Goodluck Contact Number: Enomen Goodluck

Nature of illness/ Disease with presenting complaints:

Pain on the right leg and inability to bear weight.

Said to have been playing foot ball when he twisted his ankle.

Exam: no obvious fracture, no diformity seen.

tenderness on the medial aspect of the lower 3rd of the left leg.

Relevant Clinical Finding: BP:117 TEMP:36.5 Pulse:98 Notes:risk of fall

Duration of the Present Ailment: Date of First Consultation:

Past history of Present Ailment,if any:

Provisional Diagnosis: Acute pain due to trauma ICD 10 Code:G89.11

Proposed Line of Treatment: ○ Medical Management ○ Surgical Management ○ Intensive Care ○ Investigation ○ Non Allopathic Treatment

If Investigation & Medical Management, Provide details: 96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Route of Drug Administration: (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION, POWDER FOR SOLUTION (9S, SACHET), 5, (METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY, TOPICAL AEROSOL SPRAY (150ML, SPRAY BOTTLE), 5

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? ○ Yes ○ No

Date of injury:

Reported to Police? ○ Yes ○ No

Injury/ Disease caused due to substance abuse/ alcohol consumption? ○ Yes ○ No

Test conducted to establish this? ○ Yes ○ No (If Yes, attach reports)

In case of Maternity: ○ G ○ P ○ L ○

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

## Mandatory: Past History of any chroni

if yes sin (month/y

☐ Diabetes Mellitus

☐ Heart Disease

☐ Hypertension

| | | |
|---|---|---|
| Expected cost for Investigation + Diagnostics: | | AED |
| ICU charges: | | AED |
| OT charges: | | AED |
| Professional Fee(Surgeon) + Anaesthetists Fee+ Consultation Charges: | | AED |
| Medicines + Consumables+ Cost of Implants (if Applicable please specify). Other Hospital Expenses if any: | | AED |
| All Inclusive package charges applicable,if any: | | AED |
| Probable Date of Admission : | | |
| Less than 24 Hours: | ○ Yes ○ No | |
| Sum Total Expected Cost of Hospitalization: | | AED |

- ☐ Hyperlididemias
- ☐ Osteoarthritis
- ☐ Asthma/ COPD/ Bronchitis
- ☐ Cancer, Tumor, Cyst or growth of any kind
- ☐ Alcohol or drug abuse
- ☐ Any HIV or STD/ Related Ailments
- ☐ Epilepsy or Tuberculosis
- ☐ Any Physical Disability or Disease of Eye
- ☐ Depression, Mental or psychiatric condition
- ☐ Disorder of bones, joints or muscles
- ☐ Stroke, Anemia, any Blood Disorder, Chest Pain, elevated cholesterol, disorder of kidney or genitor– urinary system, liver disorder, hepatitis (including
- ☐ Any disease or Disorder of Brain & Nervous System,
- ☐ 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
- ☐ Any other ailment give details:

Medical Plan ( Itemized Orginal Invoices and Applicable Prescriptions/ Reports/ Results must be consider claim)

| Pharmacy | Estimated Cost |
|---|---|
| (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION | 0.0000 |
| (METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY | 0.0000 |

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 patients' discharge.
3) All non-medical expenses and expenses not relevant to the hospitalization or illness which is not payable by INAYAH TPA 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 a 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) afte
2) In case INAYAH TPA (L.L.C) is not liable to settle the hospital bill to discrepancy in documentation, I take complete respo settle the bill.
3) All non-medical expenses, expenses not relevant to the present hospitalization amount, over and above the limit authorized 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 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 p 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 statement, suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited. I fu that in respect of the above treatment no benefits are admissible under any other medical scheme or insurance.

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

**Provider's Seal**

**Treating Doctor's Signature**

**Patient/Insured Signature**

**SAA**
**H**

**Patient/**