MOHAMMAD HAKAM

☑ ☐ 23-06-1980 6R8Q-A-NLCR-G23

INAYAH TPA LLC 0524486546

06-12-2024

pc: flu

sore throat

pain

headache

Acute upper respiratory infection, unspecified, Acute nasopharyngitis [common cold], Low back pain, Acute bronchitis, unspecified, Gastro-esophageal reflux disease without esophagitis

J06.9, J00, M54.5, J20.9, K21.9

☐ ☐ ☐ ☐

AHSAN HUSSAIN

0521644729

999-9999-9999999-9

MOHAMMAD HAKAM

INAYAH TPA (L.L.C.)
(A Wholly Owned Subsidiary of)
الوطنية للتأمين على الحياة والعام
NATIONAL LIFE & GENERAL INSURANCE
Ominvest Group مجموعة أومينفست

Pre -Authorization Form

Kindly forward all approval requests to approvals@inayahtpa.com

Provider- OP Direct Billing Claim Form

Details of the Third Party Administrator			
Toll free/ Phone Number:	800-462924 / 04 3552354	Fax:	04 3512339

To be filled by the Insured / Patient		
Name of the Patient:		
Gender: ☐ Male ☐ Female	DOB :	Inayah ID Number:
Corporate Name:		Policy Ref Number:
Name of Insurance Company:		Contact Number:

Patient's Declaration:

I declare that all the details given on this claim form are true and accurate and 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. In case INAYAH LLC is not liable to settle the hospital bill to discrepancy in documentation, I take complete responsibility to settle the bill. For this claim I authorise any medical practitioner, Specialist, Conultant who has attended me/the patient, in the past or present, to give any details that may be asked by INAYAH TPA LLC.

Patient's/Member's Signature	Date:

To be filled by the treating Doctor / Hospital		
Nature of illness/Present complaints:		
Duration of the Present ailment:		
Date of First Consultation:		
Past medical history if any:		
Provisional Diagnosis:		ICD 10 Code:
Type of condition: ☐ Acute ☐ Chronic		
Line of Treatment : ☐ Medical Management ☐ Investigation ☐ Radiology ☐ Pharmacy		
Provider/Treating Physician Stamp:	Treating Physicians Name:	
	Tel Number:	
	Fax Number:	
	P. O. Box No:	

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

Pharmacy - Please attach a copy of prescription	Dosage	Laboratory/ Radiology	Estimated Cost

Hospital Declaration:

1) We have no objection to any authorized official documents pertaining to insured's hospitalization. All valid original documents countersigned by the insured to be dispatched to INAYAH LLC, Dubai office within 7 days of the patients' discharge. All non-medical expenses and expenses not relevant to the hospitalization or illness which is not payable by INAYAH LLC to be collected from the patient. INAYAH LLC 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. The patient declaration has been signed by the patient or his representative in our presence.

Provider's Seal	Treating Doctor's Signature	Patient/Insured Signature	Patient/ Insured Name
		Parent signature in case of minor	