INAYAH TPA (L.L.C)

Pre -Authorization / Direct Billin

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: SYED TEHSEER SYED FIROZ

Gender: (●) Male ( ) Female Age:32Y - 6M - 5D Contact Number: 0558619345

INAYAH ID Card Number: 5I4J-A-NLCR-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: PC: Nasal congestion, itching nose, running nose
Duration: 3days
has associated dry cough

Relevant Clinical Finding: BP:132 TEMP:36 Pulse:96 Notes:risk of fall

Duration of the Present Ailment: Date of First Consultation:

Past history of Present Ailment,if any:

Provisional Diagnosis: Acute upper respiratory infection, unspecified, Allergic rhinitis, unspecified, Acute ethmoidal sinusitis, unspecified, Cough

ICD 10 Code:J06.9, J30.9, J01.20,

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

If Investigation & Medical Management, Provide details:

Route of Drug Administration: (MOMETASONE FUROATE (AS MONOHYDRATE : 50 MCG/DOSE NASAL SPRAY, NASAL SPRAY (120 DOSE, PUMP SPRAY, 5,(LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 MG TABLETS, TABLETS (14S, BLISTER PACK, 7,(IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS, FILM COATED TABLETS (16S, BLISTER, 4,(CEFIXIME : 400 MG) CAPSULES (HARD GELATIN), CAPSULES (HARD GELATIN) (6S, BLISTER PACK), 6,(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE), SYRUP (SUGAR FREE) (120ML, GLASS 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 ○ A

LMP:

Detail(s) of Patient Admitted:

Date of Admission:

Time:

Is this an Emergency/Planned Hospitalization?

Mandatory: Past History of any chronic il

if yes since (month/year

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
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

- ☐ Diabetes Mellitus /
- ☐ Heart Disease /
- ☐ Hypertension /
- ☐ 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 enc consider claim)

Pharmacy	Estimated Cost
(MOMETASONE FUROATE (AS MONOHYDRATE : 50 MCG/DOSE NASAL SPRAY	26.0000
(LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 MG TABLETS	1.1400
(IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS	0.9400
(CEFIXIME : 400 MG) CAPSULES (HARD GELATIN)	0.0000
(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE)	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 days of 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 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 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 disch
2) In case INAYAH TPA (L.L.C) is not liable to settle the hospital bill to discrepancy in documentation, I take complete responsibilit the bill.
3) All non-medical expenses, expenses not relevant to the present hospitalization amount, over and above the limit authorized b 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 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 particu 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 o

statement, suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited. I furt
declare 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

SYED TEHS
FIR

Patient/
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