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: MIRRIAM NTHAMBI MUTHIANI

Gender: ○ Male ◉ Female Age:37Y - 3M - 5D Contact Number: 9715686295

INAYAH ID Card Number: 46NV-A-NLSP-G25 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: MOHAMMED M HAMED Contact Number: MOHAMMED M HAM

Nature of illness/ Disease with presenting complaints:

the patient came complaining of spotting

she had a positive pregnancy test 9 weeks ago

by abdominal ultrasound the uterus show gestational sac correlating to 6 weeks gestation without fetal pole

by transvaginal ultrasound the sac is irregular , empty with no fetal pulsation, picture going with abortion

Relevant Clinical Finding: BP:143 TEMP:36.3 Pulse:82 Notes:risk of fall

Duration of the Present Ailment: Date of First Consultation:

Past history of Present Ailment,if any:

Provisional Diagnosis: Missed abortion ICD 10 Code:O02.1

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

If Investigation & Medical Management, Provide details:

Route of Drug Administration: (DOXYCYCLINE : 100 MG) TABLETS, TABLETS (10S, BLISTER PACK), 5, (METRONIDAZOLE : 250 MG TABLETS, TABLETS (20S, BOX, 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

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 AED

Mandatory: Past History of any chroni

if yes sin (month/

☐ Diabetes Mellitus

☐ Heart Disease

☐ Hypertension

☐ Hyperlididemias

☐ Osteoarthritis

☐ Asthma/ COPD/ Bronchitis

specify). Other Hospital Expenses if any:

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

☐ 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
(DOXYCYCLINE : 100 MG) TABLETS	0.0000
(METRONIDAZOLE : 250 MG TABLETS	0.5300

Laboratory/Radiology	Es Co
ULTRASOUND ROUTINE	25
Ultrasound, abdominal, real time with image documentation; complete	68
Ultrasound, transvaginal	10

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 day

patients' discharge.
3) All non-medical expenses and expenses not relevant to the hospitalization or illness which is not payable by INAYAH TPA (L 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 t 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 d
2) In case INAYAH TPA (L.L.C) is not liable to settle the hospital bill to discrepancy in documentation, I take complete responsi the bill.
3) All non-medical expenses, expenses not relevant to the present hospitalization amount, over and above the limit authoriz 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 t 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 par 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 fals statement, suppression or concealment my right to claim reimbursement of the said expenses shall be absolutely forfeited. I 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

MIRRIA
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Patient/ I