ICD 10 Code: 002.1



Provisional

Diagnosis:

Missed abortion

## 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: O Male Female Age:37Y - 3M - 5D Contact Number: 9715686295 46NV-A-NLSP-G25 **INAYAH ID Card Number:** Policy Number/Corporate: Currently do you have any other Mediclaim/ Health Insurance O Yes O 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 Contact Treating MOHAMMED M HAMED MOHAMMED M HAM Number: Doctor: the patient came complaining of spotting Nature of she had a positive pregnancy test 9 weeks ago illness/ Disease with presenting by abdominal ultrasound the uterus show gestational sac correlating to 6 weeks gestation without fetal pole complaints: by transvaginal ultrasound the sac is irregular, empty with no fetal pulsation, picture going with abortion Relevant BP:143 TEMP:36.3 Pulse:82 Notes:risk of fall Clinical Finding: Duration of the Date of First Present Consultation: Ailment: Past history of Present Ailment, if any:

Proposed Line of Treatment:	<ul> <li>○ Medical Management ○ Surgical Management ○ Intensive Care</li> <li>○ Investigation ○ Non Allopathic Treatment</li> </ul>						
If Investigation & Medical Management, Provide details:	ū	·					
Route of Drug Administration:	Territoria de la companya della companya della companya de la companya della comp	MG) TABLETS, TABLETS 250 MG TABLETS, TABL		•			
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? O Yes O	○ No			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:	$\bigcirc$ G $\bigcirc$ F	010
LMP:							
	etail(s) of Patie	nt Admitted:		Mandato	ory: Past His	tory of an	y chroni
Date of Admissi	on: Tir	me:					if yes sin (month/
Is this an Emerg				☐ Diabetes N	Mellitus		
Expected No. of Hospital:	days of stay in		Days	☐ Heart Dise	220		
Room Type/Category:			Treatt Disease				
Per Day Room F and Service Cha Diet:			AED	☐ Hypertens	ion		
Expected cost for + Diagnostics:	or Investigation		AED				
ICU charges:			AED	☐ Hyperlididemias			
OT charges:			AED	☐ Osteoarth	ritis		
Professional Fee Anaesthetists Fe Charges:	e(Surgeon) + ee+ Consultation		AED				
	nsumables+ Cost applicable please		AED	Asthma/ COPD/ Bronchitis			

specify). Other Hospital Expenses if any:			☐ Cancer, Tumor, Cyst or growth of any	
All Inclusive package charges applicable, if any:		AED	kind	
Probable Date of Admission :			☐ Alcohol or drug abuse	
Less than 24 Hours:	○ Yes ○ No			
Sum Total Expected Cost of Hospitalization:		AED	☐ 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 O		pplicable consider	Prescriptions/ Reports/ Results mu	ıst be

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	1(

## **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.

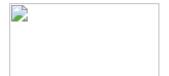
- 3) All non-medical expenses and expenses not relevant to the hospitalization or illness which is not payable by INAYAH TPA (L collected from the patient.
- 4) INAYAH TPA (L.L.C) will not be liable to make the payment in the event of any discrepancy between the facts presented at submission of final 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 authorized (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.

Dr. Mohammed M Hamed Hashish Specialist Obstetrics And Gynecology DHA NO: 75385955-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.

**Provider's Seal** 



**Treating Doctor's Signature** 



**Patient/Insured Signature** 

MIRRIA ML

Patient/ I