



Pre -Authorization / Direct Billing

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: SIMRAN CHAUDHARY
Gender: ☐ Male ☒ Female Age: 28Y - 1M - 7D Contact Number: 0554857924
INAYAH ID Card Number: 45HR-A-NLCR-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: KEERTHANA Contact Number: KEERTHANA
PC bodypain, headache, tiredness, cough
HOPC pt presented with complaints of bodypain, headache, tiredness, cough since morning
Nature of illness/ Disease with presenting complaints: No drug allergy
Nil comorbs
O/E Chest clear, looks pale and dehydrated
Tonsils normal
Relevant Clinical Finding: BP:110 TEMP:37.2 Pulse:80 Notes: Risk of fall
Duration of the Present Ailment: Date of First Consultation:

Past history of Present Ailment,if any:

Provisional Diagnosis:

Pain, unspecified, Weakness, Headache, unspecified, Acute bronchitis, unspecified, Dehydration, Fever, unspecified, Cough

ICD 10 Code:R52, R53.1, R51 R50.9, R05

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,96365, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour,96361, Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)

Route of Drug Administration:

(PARACETAMOL : 500 MG) FILM COATED TABLETS, FILM COATED TABLETS (96S, BLISTER PACK), 3,(OXOMEMAZINE : 0.33 MG/ML) SYRUP, SYRUP (150ML, PLASTIC 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:

Mandatory: Past History of any chronic

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

☐ Diabetes Mellitus

☐ Heart Disease

☐ Hypertension

if yes sin (month/

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

☐ Hyperlipidemias

☐ 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 Original Invoices and Applicable Prescriptions/ Reports/ Results must be consider claim)

Pharmacy	Estimated Cost
(PARACETAMOL : 500 MG) FILM COATED TABLETS	0.0000
(OXOMEMAZINE : 0.33 MG/ML) SYRUP	0.0000

Hospital Declaration:

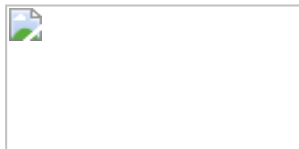
- 1) We have no objection to any authorized official documents pertaining to insured's hospitalization.
- 2) All valid original documents countersigned by the insured to be dispatched to INAYAH TPA (L.L.C), Dubai office within 7 day patients' discharge.
- 3) All non-medical expenses and expenses not relevant to the hospitalization or illness which is not payable by INAYAH TPA (L.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 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:

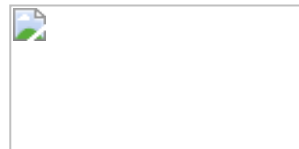
- 1) I agree to allow the hospital to submit all original documents pertaining to the hospitalization to INAYAH TPA (L.L.C) after discharge.
- 2) In case INAYAH TPA (L.L.C) is not liable to settle the hospital bill to discrepancy in documentation, I take complete responsibility for the bill.
- 3) All non-medical expenses, expenses not relevant to the present hospitalization amount, over and above the limit authorized by INAYAH 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 particular standard.
- 6) I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I 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 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

SIMRAN

Patient/