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

Pre -Authorization Form

Kindly forward all approval requests to approvals@inayahtpa.com

Provider- OP Direct Billing Claim Form

Details of the Third Party Administrator

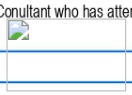
Toll free/ Phone Number: 800-462924 / 04 3552354 Fax: 04 3512339

To be filled by the Insured / Patient

Name of the Patient: SIMRAN CHAUDHARY		
Gender: ☐ Male ☑ Female	DOB : 16-06-1997	Inayah ID Number: 45HR-A-NLCR-G25
Corporate Name:		Policy Ref Number:
Name of Insurance Company: INAYAH TPA LLC		Contact Number: 0554857924

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: 22-07-2025

To be filled by the treating Doctor / Hospital

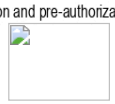
Nature of illness/Present complaints: PC bodypain,headache,tiredness ,cough	
Duration of the Present ailment: HOPC pt presented with complaints of bodypain headache tiredness,cough since morning	
Date of First Consultation:	
Past medical history if any: No drug allergy Nil comorbs	
Provisional Diagnosis: Headache, unspecified, Pain in Chest wall, Dehydration, Weakness	ICD 10 Code: R51.9, R52, E86.0, R53.1
Type of condition: ☐ Acute Tonsils r/o mal ☐ Chronic	
Line of Treatment : ☐ Medical Management ☐ Investigation ☐ Radiology ☐ Pharmacy	
Provider/Treating Physician Stamp:	Treating Physicians Name: KEERTHANA
	Tel Number:
	Fax Number:
	P. O. Box No: 999-9999-9999999-9

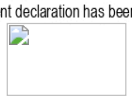
Medical Plan (Itemized Orginal Invoices and Applicable Prescriptions/ Reports/ Results must be enclosed to consider claim)

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.





SIMRAN CHAUDHARY

Provider's Seal | Treating Doctor's Signature | Patient/Insured Signature | Patient/ Insured Name

Parent signature in case of minor