

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: BEENISH BILLU WILLIAM

Gender: ☐ Male ☒ Female

DOB: 10-01-1991

Inayah ID Number: 4FB8-A-NLCR-G25

Corporate Name:

Policy Ref Number:

Name of Insurance Company: INAYAH TPA LLC

Contact Number: 0506082785

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, Consultant 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: 30-07-2025

To be filled by the treating Doctor / Hospital

Nature of illness/Present complaints:

pc : low back pain and pain in passing urine

Duration of the Present ailment: pt came with the complain of difficulty

passing urine for one week

Date of First Consultation:

she has delivered 2.5 month back

Past medical history if any:

history of gestational diabetes

Provisional Diagnosis: Urinary tract infection, site not specified, Dysuria, Dehydration, Vitamin D deficiency, unspecified

ICD 10 Code: N39.0, R30.0, E86.0, E55.9

Type of condition: ☐ Acute ☐ Chronic

Line of Treatment : ☐ Medical Management ☐ Investigation ☐ Radiology ☐ Pharmacy

Provider/Treating Physician Stamp:

Treating Physicians Name: AISHA

Tel Number:

Fax Number:

P. O. Box No: 999-9999-9999999-9

Medical Plan (Itemized Original 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.

Dr. Aisha Umer
Physician - General Practitioner
DHA-452648-02
CITYCARE MEDICAL CENTER
DUBAI - UAE

Aisha

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BEENISH BILLU WILLIAM

Provider's Seal

Treating Doctor's Signature

Patient/Insured Signature

Patient/ Insured Name

Parent signature in case of minor

P.O. Box: 111032, Dubai - United Arab Emirates, Tel:+971 4 3552354, Fax: +971 4 3512339, Web: www.inayahtpa.com