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: FIRAS AHMAD MAJDI ALTURJMAN

Gender: (●) Male ( ) Female Age:26Y - 0M - 23D Contact Number: 052313389(

INAYAH ID Card Number: 46XI-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

Nature of illness/ Disease with presenting complaints:

PC throat pain,tiredeness,fever,cough,sneezing,bodypain

HOPC throat pain,tiredeness,fever,cough,sneezing,bodypain since 4 days

O\E chest clear

Tonsils erythematous and infected

No drug allergy

Nil comorbs

Relevant Clinical Finding: BP:120 TEMP:37.6 Pulse:72 Notes:RISK OF FALL

Duration of the Present Ailment:

Date of First Consultation:

Past history of Present Ailment,if any:

Provisional Diagnosis: Acute tonsillitis, unspecified, Fever, unspecified, Pain, unspecified, Cough, Allergic rhinitis, unspecified, Dehydration, Acute gastritis without bleeding

ICD 10 Code:J03.90, R50.9, R E86.0, K29.00

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

If Investigation & Medical Management, Provide details: 96360, Intravenous infusion, hydration; initial, 31 minutes to 1 hour,96375, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure),96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Route of Drug Administration: (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS, TABLETS (20S, BLISTER PACK), 5,(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN), CAPSULES (HARD GELATIN) (14S, BLISTER), 5,(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS, CAPLETS (24S, BOX), 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:

Date of Admission:

Time:

Is this an Emergency/Planned Hospitalization?

Expected No. of days of stay in Hospital: Days

Room Type/Category:

Mandatory: Past History of any chroni

☐ Diabetes Mellitus

☐ Heart Disease

if yes sin (month/

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 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

☐ Hypertension

☐ Hyperlididemias

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

Pharmacy	Estimated Cost
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	0.0000
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	0.0000
(OXOMEMAZINE : 0.33 MG/ML) SYRUP	0.0000

Laboratory/Radiology	
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	1
C-reactive protein;	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 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.

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذم م
CITICARE MEDICAL CENTER LLC

Provider's Seal

Treating Doctor's Signature

Patient/Insured Signature

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Patient/ Ir