

**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: 0523133890
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

PC throat pain, tiredness, fever, cough, sneezing, body pain

HOPC throat pain, tiredness, fever, cough, sneezing, body pain since 4 days

Nature of
illness/ Disease
with presenting
complaints:

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:

Mandatory: Past History of any chroni

Date of Admission:

Time:

Is this an Emergency/Planned
Hospitalization?

Expected No. of days of stay in
Hospital:

Days

Room Type/Category:

☐ 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

☐ 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 considered for 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
C-reactive protein;

Hospital Declaration:

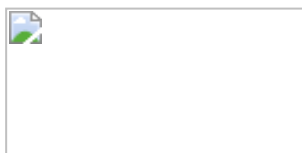
- 1) We have no objection to any authorized official documents pertaining to insured's hospitalization.
- 2) All valid original documents countersigned by the insured to be dispatched to INAYAH TPA (L.L.C), Dubai office within 7 days of patients' discharge.
- 3) All non-medical expenses and expenses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

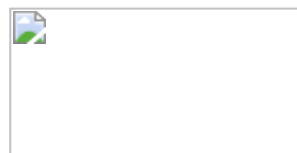
- 1) I agree to allow the hospital to submit all original documents pertaining to the hospitalization to INAYAH TPA (L.L.C) after discharge.
- 2) In case INAYAH TPA (L.L.C) is not liable to settle the hospital bill to discrepancy in documentation, I take complete responsibility for the bill.
- 3) All 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

**FIRAS AHMED
ALTU**

Patient/Insured