

**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: LIXTER DE LA CRUZ
Gender: ☒ Male ☐ Female Age: 40Y - 5M - 4D Contact Number: 0561303014
INAYAH ID Card Number: G2CS-A-NLBR-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 fever, headahce, cough, pain in throat

HOPC pt presents with complaints of fever, headahce, cough, pain in throat since 2 days

Nature of illness/ Disease with presenting complaints:
O\E chest clear
Tonsils inflamed and infected
He looks dehydrated

K\C\O HTN

nodrug allergy

Relevant Clinical Finding: BP:134 TEMP:38.2 Pulse:88 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, Essential (primary) hypertension, Fever, unspecified, Pain in throat, Cough, Other gastritis without bleeding, Hyperlipidemia, unspecified

ICD 10 Code:J03.90, I10, R50.
K29.60, E78.5

Proposed Line
of Treatment:

☐ Medical Management ☐ Surgical Management ☐ Intensive Care
☐ Investigation ☐ Non Allopathic Treatment

If Investigation
& Medical
Management,
Provide details:

96365, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour,96374, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug,96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular,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)

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,(OXOMEMAZINE : 0.33 MG/ML) SYRUP, SYRUP (150ML, PLASTIC BOTTLE), 5,(PARACETAMOL : 500 MG) FILM COATED TABLETS, FILM COATED TABLETS (96S, BLISTER PACK), 2,(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS, FILM COATED TABLETS (28S, BLISTER PACK), 90

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:

if yes sin
(month/

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

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

☐ Diabetes Mellitus

☐ Heart Disease

☐ 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 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
(OXOMEMAZINE : 0.33 MG/ML) SYRUP	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	0.0000
(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS	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:

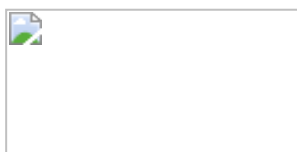
- 1) We have no objection to any authorized official documents pertaining to insured's hospitalization.
- 2) All valid original documents countersigned by the insured to be dispatched to INAYAH TPA (L.L.C), Dubai office within 7 day patients' discharge.
- 3) All non-medical expenses and expenses not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

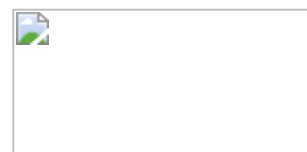
- 1) I agree to allow the hospital to submit all original documents pertaining to the hospitalization to INAYAH TPA (L.L.C) after discharge.
- 2) In case INAYAH TPA (L.L.C) is not liable to settle the hospital bill to discrepancy in documentation, I take complete responsibility for the bill.
- 3) All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

LIXTI

Pat