INAYAH TPA (L.L.C)

Reimbursement Claim Form

INAYAH REIMBURSEMENT CLAIM FORM

Issuance of this form does not amount to admission of any liability of under the policy on the part of the insurers. Please give the following information correctly and completely to enable us process your claim promptly. If the claim is under Personal Accident Insurance, please complete a Personal Accident Claim Form.

All dates to be entered as Date / Month / Year

1 Name of the Insured/patient *(in whose name policy is issued):*

a) Inayah Member ID:

b) Policy Number:

c) Date of Birth (Patient):

d) Email-ID:

e) Residential Address:

e) Contact No.:

f) Fax No.:

2) Nature of Disease/Illness contracted or injury sustained:

3) Date on which injury was sustained/Disease or illness first detected:

Provider/Treating Physician Stamp:	Treating Physicians Name:
	Tel Number:
	Fax Number:
	P. O. Box No:

Clinic:

a Date of Admission:

b Date of Discharge:

c Registration No.:

8 Are you at present covered under any other similar type of scheme like P.A. Cancer Insurance, Mediclaim (Individual or Group), Health Insurance, etc. If Yes, Please give particulars of each:

a) Is this the first year of coverage under Mediclaim Policy? Yes / No
If no, since when have you been continuously insured under Mediclaim Policy. Give details

b) i) Is this the first claim under this policy ? Yes / No
ii) If no, please quote Previous claim number and details

In support of the above claim, I enclose the following original documents (Please indicated by)

1) Bill, Receipt and Discharge certificate / card from the Hospital.
2) Pathological test reports
3) Duly filled claim form by the medical practitioner

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed:

Total of Hospital Bill	AED.	
Medicines purchased from chemists	AED.	
Other expenses not included above	AED.	
Grand Total	AED.	

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.

I also authorize TPA to receive payment from insurance company as reimbursement of hospital bills incurred on my treatment.

Provider's Seal	Treating Doctor's Signature	Patient/Insured Signature Parent signature in case of minor	Patient/ Insured Name