INAYAH TPA (L.L.C.)
(A Wholly Owned Subsidiary of)
الوطنية للتأمين على الحياة والعام
NATIONAL LIFE & GENERAL INSURANCE
Ominvest Group
مجموعة اومينفست

Reimbursement Claim Form

Please Use **BLOCK** letters to fill this form.
Please ensure that all sections are fully completed and attach all original receipt(s) showing the diagnosis and a full breakdown of cost for each condition being claimed.

Section 1 Member/Patient Information

Principal Insured Name	
Inayah Member ID No: (xxxx-x-xxxx-xxx)	
Patient's name	
Patient's Date of birth	
Employee No/ Staff ID: (If applicable)	
Group Name (If applicable)	
Principal Insured's Tel number (mobile)	
Principal Insured's Email address	
Nationality	

Section 2 Medical Information

(To be fully completed by patient's medical practitioner – all boxes must be completed in BLOCK letters.)

Country of Treatment	
Provider's name: Physician's Name:	Physician's /telephone/ fax/ email:
Physician's address :	Date of first symptoms noticed:
I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.	Physician's signature and stamp: Date:
Diagnosis (Please provide precise diagnosis or symptom (s) and details of any test (s) conducted) Primary: Secondary:	

Section 3 Financial Section (to be completed by the Principal Insured/Guardian)

Outpatient Treatment	**Claimed Amount and Currency**	**Inpatient Treatment****	**Claimed Amount and Currency**
Consultation		Consultation	
Pharmacy		Pharmacy	
Diagnostic/Lab/Others		Diagnostic/Lab/Others	
Total Claimed Amount and Claimed Currency			

Please retain a copy for your records

INAYAH TPA (L.L.C.)
(A Wholly Owned Subsidiary of)
الوطنية للتأمين على الحياة والعام
NATIONAL LIFE & GENERAL INSURANCE
Ominvest Group
مجموعة اومينفست

Reimbursement Claim Form

Section 4 Bank Details

Principal Insured Name	
Bank Account Holder Name	
IBAN number	
Swift Code	
Name of the Bank	
Branch	

Please recheck the Bank Account details before submission. The employee/Claimant shall be responsible for wrong bank transfers affected due to incorrect Bank details provided by him/her.

Section 5 Documents' Submission (IMPORTANT)

Please submit the following documents in Original:

a. Original invoices and receipts with itemized breakdown
b. Original medical report from your treating physician
c. Original or copies of report/result of investigations carried out
d. Complete Reimbursement Claim Form
e. Discharge Summary and copy of prior approval (for inpatient cases only)

**NOTE: INAYAH pre-approval is required for all In-patient treatment. Before admission/surgery, you are required to send to INAYAH a detailed medical report and cost estimate of the proposed surgical procedure/treatment on the letterhead of the hospital with affixed physician's stamp and signature along with the result of relevant investigations carried out and e- mail it to approvals@inayahtpa.com. Thereafter, you shall receive a reply from INAYAH regarding reimbursement coverage.

All Documents must be submitted in English or Arabic, documents in other languages must be translated prior to submission.

Section 6 Patient's Declaration and Consent

I confirm I am the patient/patient's spouse or guardian (if patient is under 18 years of age) claim benefits and declare that all the particulars given above are to the best of my knowledge true and correct. In addition, I, the undersigned, authorize and request any hospital, physician, and any other health provider to furnish INAYAH TPA LLC with the complete information including copies of their records in connection with medical treatment or other services provided to me or to my dependent.

I agree that a copy of this consent shall have the validity of the original

Signature of the Patient/Patient's Spouse /Guardian and wish to

Date / / 20

Please retain a copy for your records