Pre -Authorization Form

Kindly forward all approval requests to approvals@inayahtpa.com

Provider- OP Direct Billing Claim Form

Details of the Third-Party Administrator		
Toll free Number: 800-462924		
To be filled by the Insured / Patient		
Name of the Patient:		
Gender: ☐ Male ☐ Female	DOB :	Inayah ID Number:
Corporate Name:		Policy Ref Number:
Name of Insurance Company:		Contact Number:

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.

Patient's/Member's Signature	Date:

To be filled by the treating Doctor / Hospital				
Nature of illness/Present complaints:				
Duration of the Present ailment:				
Date of First Consultation:				
Past medical history if any:				
Provisional Diagnosis:				ICD 10 Code:
Type of condition: ☐ Acute ☐ Chronic				
Line of Treatment : ☐ Medical Management	☐ Investigation	☐ Radiology	☐ Pharmacy	
Provider/Treating Physician Stamp:			Treating Physicians Name:	
			Tel Number:	
			Fax Number:	
			P. O. Box No:	

Head Office Dubai
PO.BOX: 111032, Office: 203, 2nd floor, Al Garhoud Business Center, Al Garhoud, Dubai, UAE.

Abu Dhabi Branch
PO.BOX : 26551, 20th Floor- Royal Business Center, Al Wahda Commercial Tower, Haza Bin Zayed the 1st Street (Defense Road) - Abu Dhabi - UAE

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Medical Plan (Itemized Orginal Invoices and Applicable Prescriptions/ Reports/ Results must be enclosed to consider claim)			
Pharmacy - Please attach a copy of prescription	Dosage	Laboratory/ Radiology	Estimated Cost

Hospital Declaration:

1) We have no objection to any authorized official documents pertaining to insured's hospitalization. All valid original documents countersigned by the insured to be dispatched to INAYAH LLC, Dubai office within 7 days of the patients' discharge. All non-medical expenses and expenses not relevant to the hospitalization or illness which is not payable by INAYAH LLC to be collected from the patient. INAYAH LLC 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. The patient declaration has been signed by the patient or his representative in our presence.

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

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