

Provider- Dental Direct Billing Claim Form

Details of the Third Party Administrator

Toll free/ Phone Number: **800-462924 / 04 3552354** Fax: **04 3512339**

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, Consultant 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 present complaints:

Treatment Plan:

Consultation:

X-Ray:

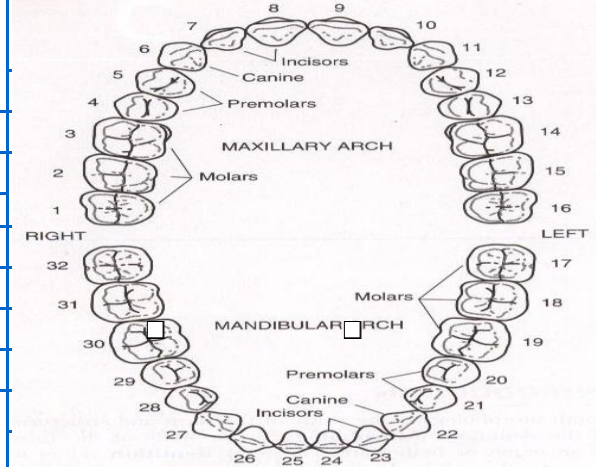
Root Canal Treatment:

Composite Filling:

Amalgam Filling:

Scaling & Polishing:

Others/Pharmacy:



Provider/Treating Physician Stamp:

Treating Physicians Name:

Tel Number:

Fax Number:

P. O. Box No:

Kindly forward all approvals to approvals@inayahtpa.com

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

Patient/ Insured Name

Parent signature in case of minor

P.O. Box: 111032, Dubai - United Arab Emirates, Tel:+971 4 3552354, Fax: +971 4 3512339, Web: www.inayahtpa.com