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
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

www.inayahtpa.com | contactus@inayahtpa.com |CBUAE Registration No: 008 |Paid up capital value to 7,847,000