



Dear Sir/Madam,

We request you to arrange your documents in the following order before claim submission.

Description	Porvided		Waived	
	Yes	No	Yes	No
Completed claim form with:				
Patient detail(Name, Inayah ID etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosis/Treatment and history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctor's signature and stamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinic stamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient's signature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Claim intimation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duly filled and signed claim form by the insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Insurance Policy(not applicable to Corporate & Group Medclaim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Main Hospital/Clinic Bill, Pharmacy Invoice & Receipts with break up of charges (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orginal Discharge Card/ Discharge Summary/ Narrative Summary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Original Medicine Bills(with the Insured's Name, Date) with supporting prescriptions (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Original Investigation Reports with bills, Receipts & Prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Details of previous claim history if any(e.g. Discharge Card, Investigation Reports etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other supporting document which may be important to the hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain a copy of investigation reports and discharge card before claims submission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pathology Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiology Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: * All Receipts above AED 10,000 must be revenue stamped.
* Notes by the Insured

Contact No of the Insured. _____
Email ID. _____ Mobile No. _____
Bank Name & Account Number _____
Signature of the Insured. _____ Signature of the Patient. _____

Received and Checked by Inayah:

Name:
Signature:
Date:

Received and Checked by Insurance Co:

Name:
Signature:
Date:

Kindly forward all your queries to contactus@inayahtpa.com