PLATFORM PROFILE

2026



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Platform Profile

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About Us

A Saudi platform built to prepare and audit medical claims before submission, and to work denials by root cause rather than one claim at a time. It runs as an intelligent layer above your existing systems — replacing nothing and changing none of your team's procedures.

Built on field experience across both banks of the industry: nine years inside a cooperative insurer, then years leading the revenue cycle inside medical facilities.

THE GAP



Where Denials Begin

Denials do not begin at the payer. They begin inside the facility, at the moment a claim is assembled without sufficient checking — and most causes are visible to a trained eye seconds before submission.

- Deferred revenue and a longer collection cycle
- Hours spent on a claim already completed once
- Denial patterns that recur with no institutional fix

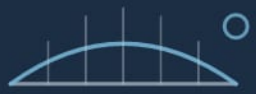
Denial ranges in the Saudi market

5% – 10%	10% – 25%	25%
Hospitals	Complexes & centres	General average
beyond which they are contested	the widest-varying band	where material leakage begins

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MISSION & VISION

Mission & Vision



Mission

That every claim leaving a Saudi facility is complete the first time — so no revenue is lost to an error that could have been caught before submission.

Vision

To close the loop of the medical insurance industry from both the payer and the provider side, with Saudi-built tools and data that stays inside the Kingdom.

HOW IT WORKS

How It Works



Reads 01

Receives your claim batch from your system as-is, with no change to your procedures

Checks 02

Examines diagnosis, documentation, coverage, classification and pricing before submission

Explains 03

Every finding points to its cause and source — a reviewable decision, not a black box

Learns 04

Analyses recurring denial patterns and addresses them at the root, not one by one

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CAPABILITIES

Capabilities

Pre-Submission Gate

Intercepts claim errors at the point of origin, before the claim leaves the facility

Denials Pyramid

Classifies denials by root cause with repair paths and evidence for appeals

CDI Engine

Links procedures to diagnoses so documentation supports the claim

Shadow Billing

A grouping-aware read of the case before real submission — for facilities handling inpatients

Price List Alignment

Matches facility pricing to national SBS codes and contracted tier

Denial Code Mapping

Translates every insurer’s taxonomy into one comparable language

Claims prepared in line with NPHIES requirements today, with a clear path to future integration

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IMPLEMENTATION

Implementation



From signature to first batch analysis — seven to fourteen days

1–2
Assessment session on your revenue cycle and current denial patterns

3–5
Account activation, permissions, and facility classification

6–9
Aligning price lists to SBS codes and connecting your systems

10–12
Training the team on the pre-submission path

13–14
First full batch analysis — where the real reading begins

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GET IN TOUCH

Let us start

We read one batch of your claims with you and show what we found — the decision is then yours.

An assessment visit to your facility · no obligation

الموقع

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حفظ جهة الاتصال

medinsup.com

00966544883175

information@medinsup.com