ANNEXURE V

F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim form

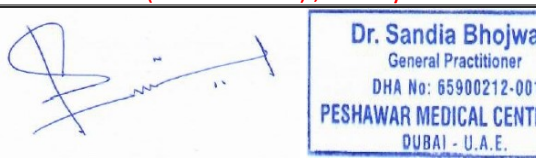
Date: 03-May-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1993-7689260-2
Card Holder's Name: SHAHENDA MOHAMED SAYED MOHAMED Age: 30Y - 5M - 6D Sex: Female
Card Holder's Tel No: Mobile No: +201069702877
Ins Card No: I011-010-120042273-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____ Nationality: Egyptian

Clinical Details: Temp 36.5 B.P. 134 Pulse. 78
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: M54.5 - Low back pain, R42 - Dizziness and giddiness, M79.10 - Myalgia, unspecified site, R11.11 - Vomiting without na

Management plan (Services inside the clinic including injections and investigations)

9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-111805-1021, (CHLORPHENIRAMIN MALEATE : 10 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy,96365, IV Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AED 40.0000) , Co.Pay

Doctor's Name: SANDIA signature with seal:



Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the abo mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or a person who has provided medical services to me to furnish any and all information with regard to any medical history, medical cor medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 03-May-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(DICLOFENAC SODIUM (AS DIETHYLAMINE) : 10 MG/G) GEL	GEL (75G, DISPENSER)	10	10