

**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

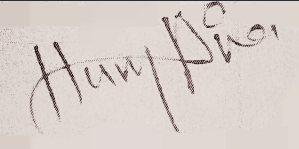
Date: 08-May-2024

Clinic Name: **Irham Medical Center Arjan** Emirates: **784-1999-8707578-7**Card Holder's Name: **Mohamed Ali Chouika** Age: **24Y - 7M - 4D** Sex: **Male**Card Holder's Tel No: Mobile No: **0561818476**Ins Card No: **I011-010-118547042-02** Valid Upto: **7/6/2024**Company **FMC NETWORK UAE**Name: **MANAGEMENT
CONSULTANCY**Employee No: _____ Nationality: **Moroccan**

Clinical Details:	Temp	B.P.	Pulse.
Signs & Symptoms:			
Date of Onset Illness :		☐ Emergency ☐ Work related ☐ New visit ☐ Follow up	
Diagnosis: Z18.10 - Retained metal fragments, unspecified, R52 - Pain, unspecified, M01.X72 - Dir infct of left ank/ft in infec/paras classd elswhr			

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

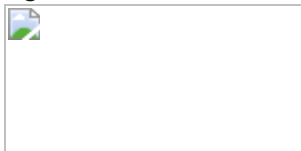
10120, REMOVE FOREIGN BODY , Co.Pay,9, Consultation Gp , General Consultation,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay

Doctor's Name: Humaira	signature with seal: 	Dr. Humaira Mumta: General Practitioner DHA No: 54155530-002 PESHAWAR MEDICAL CENTE DUBAI - U.A.E.
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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 above 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 records, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **08-May-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CIPROFLOXACIN (AS HYDROCHLORIDE) : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER)	3	3

Medicine	Dose	Duration	Quantity
(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	TABLETS (20S, BLISTER PACK)	3	9
(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (12S, BLISTER)	3	6