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

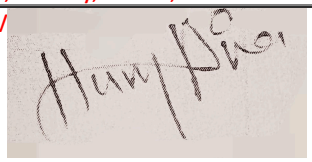
Date: 08-May-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1996-2147464-4
Card Holder's Name: SURAJ GURUNG PRITI Age: 27Y - 10M - 1D Sex: Male
Card Holder's Tel No: Mobile No: 0569172606
Ins Card No: I011-010-119490896-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Nepalese

Clinical Details: Temp37.9 B.P.136 Pulse. 86
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, J0 Acute tonsillitis, unspecified

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/M SOLUTION FOR INFUSION , Pharmacy,0006-402803-2071, VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTI Pharmacy,96365, IV Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AED 40.0000) , Co.Pay,94640, AIRWAY INHALATION TREATME Co.Pay,9, Consultation Gp , General Consultation,96374, THER/PROPH/DIAG INJ IV

Doctor's Name: Humaira 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 08-May-2024

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quantity |
|---|---|---|---|
| (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS | TABLETS (14S, BLISTER PACK) | 7 | 1 |

| Medicine | Dose | Duration | Quantity |
|---|---|---|---|
| (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS | FILM COATED TABLETS (10S, BLISTER PACK) | 7 | 7 |
| (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS | CAPLETS (48S, BOX) | 5 | 10 |
| (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE) | SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE) | 1 | 1 |