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

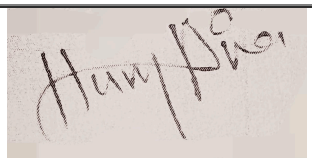
Date: 14-May-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1993-5106535-6
Card Holder's Name: ROMESH SHALITHA SILVA MIHIDU KULASOORIYA WARNA PELILAGE Age: 31Y - 0M - 23D Sex: Male
Card Holder's Tel No: Mobile No: 0501709652
Ins Card No: I011-010-118984990-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 36.6 B.P. 112 Pulse. 84
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, J03.90 - Acute tonsillitis, unspecified

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,5344-309101-1021, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETH 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9, Consultation Gp , General Cor

Doctor's Name: Humaira signature with seal:



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
PESHAWAR MEDICAL CENTE
DUBAI - U.A.E.

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 14-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	14

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 (24S, BOX)	3	6
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (1000S, BLISTER PACK)	5	15
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	1	1