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: 27-May-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-2000-5644083-5
Card Holder's Name: Marcian Abeykoon Age: 24Y - 1M - 11D Sex: Female
Card Holder's Tel No: Mobile No: 0526959357
Ins Card No: I011-010-120160022-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality: Sri Lankan

Clinical Details: Temp36.1 B.P.92 Pulse. 71
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: L03.031 - Cellulitis of right toe, R50.9 - Fever, unspecified, A49.9 - Bacterial infection, unspecified

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

96365, IV Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AED 40.0000) , Co.Pay,0005-107704-0802, TRIAXONE I.V.-(CEFTRIAXONE POWDER FOR INJECTION , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Doctor's Name: Enomen Goodluck signature with seal:

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
PESHAWAR MEDICAL CENTER LLC
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 abov 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 27-May-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(AMOXICILLIN : 875 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (14S, BLISTER PACK)	7	14
(METRONIDAZOLE : 500 MG) TABLETS	TABLETS (20S, BLISTER)	7	14

Medicine	Dose	Duration	Quantity
(TERBINAFINE (AS HCL) : 250 MG) TABLETS	TABLETS (14S, BLISTER PACK)	14	14
(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	5	10