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

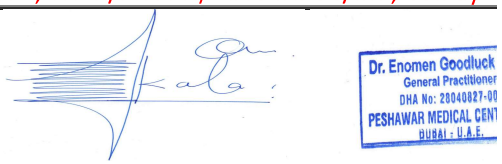
Date: 29-May-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1987-1424815-4
Card Holder's Name: ORJI MARK ABARA Age: 36Y - 8M - 0D Sex: Male
Card Holder's Tel No: Mobile No: 0523745101
Ins Card No: I011-010-112614598-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Nigerian

Clinical Details: Temp38.7 B.P.140 Pulse. 0
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: J02.9 - Acute pharyngitis, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, E86.0 - Dehyd

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

9, Consultation Gp , General Consultation,96360, HYDRATION IV INFUSION INIT , Co.Pay,0195-107704-0801, CEFTRIAXONE-TA
Pharmacy,0023-151901-1681, (DEXAMETHASONE : 1 MG/ML) (TETRAHYDROZOLINE HCL : 500 MCG/ML) (GENTAMICIN SULPH
MG/ML) EYE / EAR DROPS , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Doctor's Name: Enomen Goodluck 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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 29-May-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	10	20
(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	5	10
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	10	20

Medicine	Dose	Duration	Quant
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	7	1