

**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: 30-May-2024

Clinic Name: Irham Medical Center Arjan

Emirates: 784-1987-1424815-4

Card Holder's Name: ORJI MARK ABARA

Age: 36Y - 8M - 1D Sex: Male

Card Holder's Tel No:

Mobile No:

0523745101

Ins Card No: I011-010-112614598-02

Valid Upto: 7/6/2024

Company FMC NETWORK UAE

Name: MANAGEMENT

Employee

No:

Nationality: Nigerian



Clinical Details:

Temp

B.P.

Pulse.

Signs & Symptoms:

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: J02.9 - Acute pharyngitis, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, E86.0 - Dehydration
 K29.00 - Acute gastritis without bleeding

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-242802-0781, PANTONIX 40MG I.V. , Pharmacy,0005-150403-1021,
 PREMOSAN , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9.01, Free Follow-Up Consultation Gp , General
 Consultation,96365, IV Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AED 40.0000) , Co.Pay

Doctor's Name: Enomen Goodluck

signature with seal:

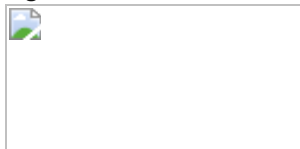


Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the 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 30-May-2024



Pharmaceuticals (to be filled by treating doctor only)