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

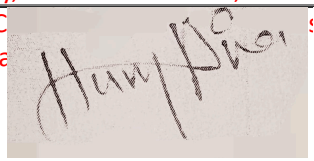
Medical Expenses Claim form

Date: 03-Jun-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1990-2831871-7
Card Holder's Name: Amar Bahadur Thapa Age: 33Y - 11M - 11D Sex: Male
Card Holder's Tel No: Mobile No: 0524395804
Ins Card No: I011-010-118066536-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Nepalese

Clinical Details: Temp37.4 B.P.109 Pulse. 82
Signs & Symptoms: risk for fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R50.9 - Fever, unspecified, R52 - Pain, unspecified, J
Allergic rhinitis, unspecified, Z72.0 - Tobacco use

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

9, Consultation Gp , General Consultation,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION I
INFUSION , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM
PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SO
MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC
1St To 1 Hr - (AED 40.0000) , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pa



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

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 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 03-Jun-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER)	7	7

Medicine	Dose	Duration	Quantity
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	7
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	7	14
(AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP	SYRUP (100ML, BOTTLE)	2	2
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	7