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

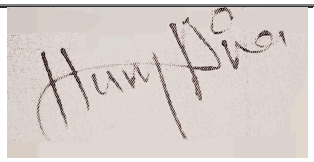
Date: 04-Jun-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1999-8707578-7
Card Holder's Name: Mohamed Ali Chouika Age: 24Y - 8M - 0D Sex: Male
Card Holder's Tel No: Mobile No: 0561818476
Ins Card No: I011-010-118547042-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Moroccan

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: R07.9 - Chest pain, unspecified, M79.604 - Pain in right leg, M62.81 - Muscle weakness (generalized)

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

9, Consultation Gp , General Consultation,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJE
Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

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 04-Jun-2024

Pharmaceuticals (to be filled by treating doctor only)