

**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: 05-Jun-2024

Clinic Name: **Irham Medical Center Arjan** Emirates: **784-1996-4736060-3**
 Card Holder's Name: **TONY EMMANUEL JOSEPH** Age: **28Y - 3M - 27D** Sex: **Male**
 Card Holder's Tel No: Mobile No: **0547626409**
 Ins Card No: **I011-010-119800663-02** Valid Upto: **7/6/2024**
 Company **FMC NETWORK UAE** Employee _____ Nationality: **Indian**
 Name: **MANAGEMENT CONSULTANCY** No: _____



Clinical Details: Temp **37** B.P. **90** Pulse. **85**
 Signs & Symptoms: **risk for fall**
 Date of Onset Illness : _____
☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
 Diagnosis: **J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, J30.9 - Allergic rhinitis, unspecified**

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

0095-107701-0802, (CEFTRIAXONE : 1000 MG) POWDER FOR INJECTION , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.P 402803-2071, VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: **Humaira**

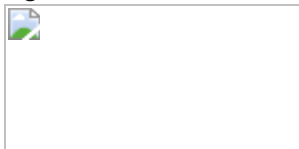
signature with seal:

Dr. Humaira Mumtaz
 General Practitioner
 DHA No: 54155530-002
PESHAWAR MEDICAL CENTE
 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 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 **05-Jun-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	1
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	7
(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	2	2