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

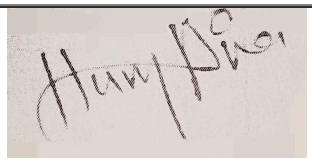
Date: 06-Jun-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1984-8519140-1
Card Holder's Name: CHAMITHDESHITHA THANTHIRIGE Age: 39Y - 5M - 29D Sex: Male
Card Holder's Tel No: Mobile No: 0503413891
Ins Card No: I011-010-120763954-01 Valid Upto: 7/6/2024
Company Name: FMC Standard Network 3 Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 39.4 B.P. 110 Pulse. 84
Signs & Symptoms: risk for fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R52 - Pain, unspecified, J03.90 - Acute tonsillitis, unspecified

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0195-107704-0
CEFTRIAXONE-TABUK IM , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96374, THER PROPH/D
PUSH SINGLE/1ST SBST/DRUG , Co.Pay,9, Consultation Gp , General Consultation

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 06-Jun-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10
(CEFUROXIME : 500 MG) TABLETS	TABLETS (10S, BLISTER PACK)	7	14

Medicine	Dose	Duration	Quantity
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (1000S, BLISTER PACK)	7	7