

**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: 19-Jun-2024

Clinic Name: Irham Medical Center Arjan

Emirates: 784-1982-9504053-3

Card Holder's Name: KAOUTAR LAOUJ

Age: 41Y - 5M - 30D Sex: Female

Card Holder's Tel No:

Mobile No:

0505240427

Ins Card No: I019-010-119713290-01

Valid Upto: 7/6/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Moroccan



Clinical Details:

Temp 37.8

B.P. 114

Pulse. 93

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, J03.90 - Acute tonsillitis, unspecified, J30.9 - Allergic rhinitis, unspecified

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 / INFUSION , Pharmacy, 96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0195-107704, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION , Pharmacy

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 19-Jun-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	7

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED 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)	1	2