ANNEXURE V

F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, P. O. BOX: 127452, ABU DHABI
Tel – 04 3977841, Fax – 04 3977842
Email – claims@fmchealthcare.ae Toll Free: 800 3426

Reimbursement Medical Expenses Claim form

(Emergency Only)

Date: 21-Oct-2023
Clinic Name: Irham Medical Center Arjan Emirates: 784-1986-7046193-2
Card Holder's Name: YAMIN HTWE Age: 37Y - 9M - 6D Sex: Female
Card Holder's Tel No: Mobile No: 0568367880
Ins Card No: I011-010-115341043-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Myanmarese

Clinical Details: Temp37.1 B.P.110 Pulse. 82
Signs & Symptoms: Risk of Fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: R51.9 - Headache, unspecified

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

Doctor's Name: Sajid Sanaullah 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 ab mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy o person who has provided medical services to me to furnish any and all information with regard to any medical history, medical c medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 21-Oct-2023

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantit
(IBUPROFEN : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	20	20
(PANTOPRAZOLE (AS SODIUM) : 40 MG) TABLETS	TABLETS (28S, BLISTER)	10	10