

**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 formDate: **24-Oct-2023**

Clinic Name: **Irham Medical Center Arjan** Emirates: **784-2005-0983639-9**
 Card Holder's Name: **RUPINDER KAUR BANSAL** Age: **18Y - 0M - 28D** Sex: **Female**
 Card Holder's Tel No: Mobile No: **0504984722**
 Ins Card No: **I011-010-115974673-01** Valid Upto: **13/8/2024**
 Company **FMC NETWORK UAE** Employee _____ Nationality: **Indian**
 Name: **MANAGEMENT CONSULTANCY** No: _____



Clinical Details: Temp **37.1** B.P. **100** Pulse. **92**
 Signs & Symptoms: **Risk of Fall**
 Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow
 Diagnosis: **J20.9 - Acute bronchitis, unspecified, J01.00 - Acute maxillary sinusitis, unspecified, J02.9 - Acute pharyngitis, unspecified, E86.0 - Dehydration**

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

2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE , Pharmacy,0125-122107-1022, DEXAMETHASONE S PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0005-111805-1021, CHLOROHISTOL 10MG Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96365, IV Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AE Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,94640, AIRWAY INHALATIC Pharmacy,0006-124513-2071, VENTOLIN NEBULES , Pharmacy

Doctor's Name: **Sajid Sanaullah**

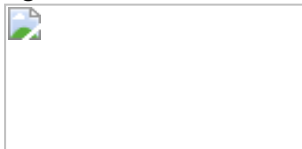
signature with seal:

Dr. Sajid Sanaullah
 General Practitioner
 DHA No: 0575821
PESHAWAR MEDICAL
 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 person who has provided medical services to me to furnish any and all information with regard to any medical history, medical records and medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **24-Oct-2023**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14
(MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (100S, BLISTER PACK)	14	14

