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: 25-Oct-2023
Clinic Name: Irham Medical Center Arjan Emirates: 784-1974-4857486-9
Card Holder's Name: JATINDER KAUR BANSAL Age: 48Y - 11M - 15D Sex: Female
Card Holder's Tel No: Mobile No: 0504984722
Ins Card No: I011-010-115974677-01 Valid Upto: 13/8/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Indian

Clinical Details: Temp39 B.P.137 Pulse. 84
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, J00 - Acute nasopharyngitis [common K29.01 - Acute gastritis with bleeding, J02.9 - Acute pharyngitis, unspecified, R09.81 - Nasal congestion, R51.9 - Headache, unspec R11.10 - Vomiting, unspecified, R05 - Cough, I10 - Essential (primary) hypertension

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

9, Consultation Gp , General Consultation,0442-106618-1001, (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AED 40.0000) , Co.Pay,2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIU CHLORIDE , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,0135-149902-0512, (DICLOFENAC SODIUM : 75 MG/3ML) INJ Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,0067-107701-0801, (CE Pharmacy,0005-242802-0781, PANTONIX 40MG I.V. , Pharmacy,0125-122107-1022 (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy

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 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 25-Oct-2023

Pharmaceuticals (to be filled by treating doctor only)