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

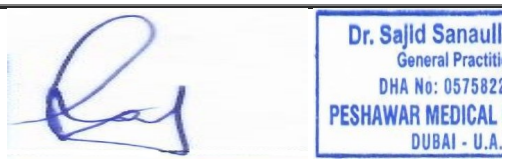
Date: 29-Oct-2023
Clinic Name: Irham Medical Center Arjan Emirates: 784-1999-5943538-1
Card Holder's Name: SOHEILA AHMED Age: 24Y - 6M - 19D Sex: Female
Card Holder's Tel No: Mobile No: 0569408670
Ins Card No: I011-010-119925749-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Egyptian

Clinical Details: Temp36.6 B.P.110 Pulse. 98
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: H10.521 - Angular blepharoconjunctivitis, right eye, H05.013 - Cellulitis of bilateral orbits

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,0003-122102-1161, (DEXAMETHASONE : 0.1 MG/ML) SYRUP , Pharma
111805-1021, CHLOROHISTOL 10MG , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

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 29-Oct-2023

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(CIPROFLOXACIN (AS HYDROCHLORIDE) : 3 MG/ML) EYE DROPS	EYE DROPS (5ML, PLASTIC DROPPER BOTTLE)	5	1
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14
(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (24S, BLISTER)	7	28