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

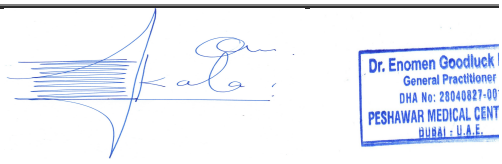
Date: 31-Oct-2023
Clinic Name: Irham Medical Center Arjan Emirates: 784-1977-3652195-2
Card Holder's Name: MONICA MWIKALI MUNYAO Age: 46Y - 3M - 4D Sex: Female
Card Holder's Tel No: Mobile No: 0543831977
Ins Card No: I011-010-115341080-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Kenyan

Clinical Details: Temp37 B.P.132 Pulse. 82
Signs & Symptoms: Risk of Fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: I10 - Essential (primary) hypertension, E78.2 - Mixed hyperlipidemia

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

9, Consultation Gp , General Consultation,82962, GLUCOSE BLOOD TEST , Lab

Doctor's Name: Enomen Goodluck 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 31-Oct-2023

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(TELMISARTAN : 80 MG) (AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	TABLETS (28S, BLISTER PACK)	28	28