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: 01-Nov-2023
Clinic Name: Irham Medical Center Arjan Emirates: 784-1988-8142652-6
Card Holder's Name: SHEEBAN KHAN GHOURI ASLAM KHAN Age: 35Y - 8M - 30D Sex: Male
Card Holder's Tel No: Mobile No: 0544412321
Ins Card No: I011-010-116510931-02 Valid Upto: 28/3/2024
Company Name: FMC NETWORK UAE Employee No: _____ Nationality: Indian

Clinical Details: Temp 37 B.P. 137 Pulse. 80
Signs & Symptoms: Risk of Fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: R19.7 - Diarrhea, unspecified, E86.0 - Dehydration

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 01-Nov-2023

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(DEXTROSE ANHYDROUS : 4 GR) (SODIUM CITRATE : 0.58G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CHLORIDE : 0.70G) ORAL POWDER	ORAL POWDER (10S, SACHET)	3	10