**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

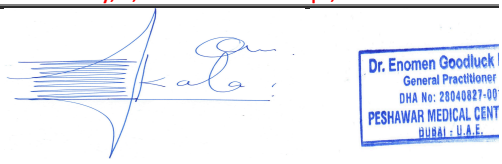
Date: 22-Mar-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1998-5037981-1
Card Holder's Name: ARSAL MEHMOOD BUTTAR AFZAAL AHMAD Age: 25Y - 7M - 28D Sex: Male
Card Holder's Tel No: Mobile No: 971567374320
Ins Card No: I019-010-118280343-01 Valid Upto: 30/11/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____ Nationality: Pakistani

Clinical Details: Temp 37.4 B.P. 120 Pulse. 80
Signs & Symptoms: Risk of Fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow
Diagnosis: J02.9 - Acute pharyngitis, unspecified, J03.90 - Acute tonsillitis, unspecified, J22 - Unspecified acute lower respiratory J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified

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

96365, IV Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AED 40.0000) , Co.Pay,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0125-122107-1022, DEXAME SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,9, Consultation Gp , General Consu

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 22-Mar-2024

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quant |
|---|---|---|---|
| (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS | FILM COATED TABLETS (20S, BLISTER PACK) | 10 | 20 |
| (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS | FILM COATED TABLETS (10S, BLISTER PACK) | 10 | 10 |
| (IBUPROFEN : 400 MG) TABLETS | TABLETS (24S, BLISTER PACK) | 5 | 10 |

| Medicine | Dose | Duration | Quant |
|---|---|---|---|
| (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE) | SYRUP (SUGAR FREE) (120ML, GLASS BOTTLE) | 7 | 1 |
| (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS | TABLETS (14S, BLISTER PACK) | 7 | 14 |