

**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: 02-Apr-2024

Clinic Name: **Irham Medical Center Arjan** Emirates: **784-1993-3629597-9**Card Holder's Name: **SYLVIA AKOTH OGILLO** Age: **30Y - 3M - 13D** Sex: **Female**Card Holder's Tel No: Mobile No: **0544738538**Ins Card No: **I011-010-117045965-02** Valid Upto: **7/6/2024**Company **FMC NETWORK UAE** Employee _____ Nationality: **Kenyan**
 Name: **MANAGEMENT CONSULTANCY** No: _____

Clinical Details:	Temp	B.P.	Pulse.
Signs & Symptoms:			
Date of Onset Illness :		☐ Emergency ☐ Work related ☐ New visit ☐ Follow	
Diagnosis: K29.00 - Acute gastritis without bleeding, R10.13 - Epigastric pain, G43.009 - Migraine w/o aura, not intractable, w/ migrainosus			

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

96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,9.01, Free Follow-Up Consultation Gp , C Consultation

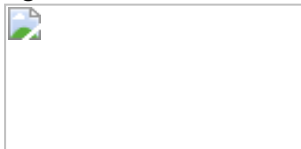
Doctor's Name: Enomen Goodluck signature with seal:	
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Diagnostic Procedures referred outside:

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 or person who has provided medical services to me to furnish any and all information with regard to any medical history, medical co medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 02-Apr-2024



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(SUMATRIPTAN : 100 MG) TABLETS	TABLETS (2S, BLISTER PACK)	4	4