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

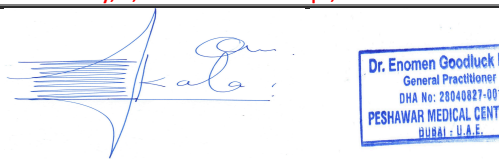
Date: 05-Apr-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-2001-2991704-1
Card Holder's Name: SULAKSHI WASANA LIYANA ARACHCHINGE Age: 23Y - 2M - 2D Sex: Female
Card Holder's Tel No: Mobile No: 0522738915
Ins Card No: I011-010-120140265-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 37.7 B.P. 104 Pulse. 98
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow
Diagnosis: J00 - Acute nasopharyngitis [common cold], J03.90 - Acute tonsillitis, unspecified, J30.9 - Allergic rhinitis, unspecified, 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,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMET SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,9, Consultation Gp , General Consultation,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay

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 05-Apr-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS	NASAL DROPS (10ML, BOTTLE)	5	1
(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

Medicine	Dose	Duration	Quant
(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER)	8	16
(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