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

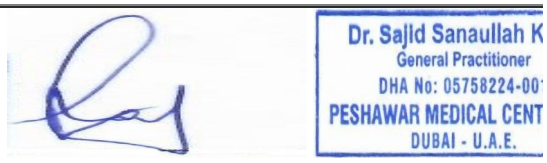
Date: 07-Apr-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1978-6549436-9
Card Holder's Name: MANORANJAN MOHAPATRA Age: 45Y - 11M - 1D Sex: Male
Card Holder's Tel No: Mobile No: 0507285561
Ins Card No: I038-010-114566909-01 Valid Upto: 22/3/2025
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Indian

Clinical Details: Temp36.8 B.P.120 Pulse. 82
Signs & Symptoms: Risk of Fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: M54.5 - Low back pain, M62.830 - Muscle spasm of back

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

5344-309101-1021, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consulta
General Consultation

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 abo mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or a person who has provided medical services to me to furnish any and all information with regard to any medical history, medical cor medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 07-Apr-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	P
(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (50G, TUBE)	5	1	0