

**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 formDate: **15-Apr-2024**Clinic Name: **Irham Medical Center Arjan** Emirates: **784-1987-8465913-2**Card Holder's Name: **MASOOD** Age: **36Y - 7M - 1D** Sex: **Male**Card Holder's Tel No: Mobile No: **05699845664**Ins Card No: **102-302-0006119301-01** Valid Upto: **11/3/2025**Company **FMC NETWORK UAE**Name: **MANAGEMENT** Employee No: _____ Nationality: **Pakistani****CONSULTANCY**Clinical Details: Temp **3701** B.P. **124** Pulse. **93**Signs & Symptoms: **risk of fall**Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: **J02.8 - Acute pharyngitis due to other specified organisms, J03.80 - Acute tonsillitis due to other specified organisms, J30.0 - 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,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMETHA SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,9, Consultation Gp , General Consultation,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay

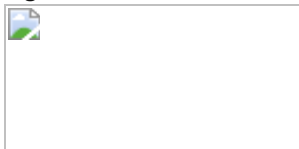
Doctor's Name: **Enomen Goodluck**

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 above 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 records, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **15-Apr-2024**Pharmaceuticals (to be filled by treating doctor only)

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

Medicine	Dose	Duration	Quantity
(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 : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER)	5	10
(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	2