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

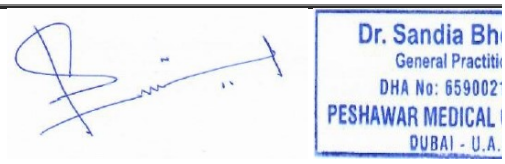
Date: 17-Apr-2024
Clinic Name: Irham Medical Center Arjan Emirates: 784-1994-3336758-0
Card Holder's Name: SHABRAZ MUHAMMAD AKRAM Age: 29Y - 6M - 6D Sex: Male
Card Holder's Tel No: Mobile No: 0569223735
Ins Card No: I011-010-118093063-02 Valid Upto: 7/6/2024
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Pakistani

Clinical Details: Temp36.8 B.P.123 Pulse. 73
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: N23 - Unspecified renal colic

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

86140, C REACTIVE PROTEIN , Lab,81005, URINALYSIS , Lab,0005-149902-1021, CLOFEN , Pharmacy,9, Consultation Gp , Gener Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Doctor's Name: SANDIA 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 17-Apr-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantit
(DICLOFENAC POTASSIUM : 25 MG) COATED TABLETS	COATED TABLETS (20S, BLISTER PACK)	5	5