

**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: **24-Apr-2024**Clinic Name: **Irham Medical Center Arjan**Emirates: **784-1997-3531750-7**Card Holder's Name: **SHAHBAZ MUNIR MUHAMMAD**Age: **27Y - 0M - 23D**Sex: **Male**Name: **MUNIR**

Card Holder's Tel No:

Mobile No:

0561328217Ins Card No: **I020-010-116885453-02**Valid Upto: **27/4/2024**Company: **FMC NETWORK UAE**

Employee

Name: **MANAGEMENT**

No:

Nationality: **Pakistani**

CONSULTANCY



Clinical Details:

Temp **37.1**B.P. **117**Pulse. **92**Signs & Symptoms: **risk of fall**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
Diagnosis: **R50.9 - Fever, unspecified, R52 - Pain, unspecified, R53.1 - Weakness**Management plan (Services inside the clinic including injections and investigations)

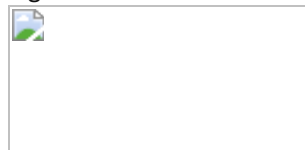
5185-106618-1001, (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK (CEFTRIAXONE : 1 G) POWDER FOR INJECTION , Pharmacy,9, Consultation Gp , General Consultation,96365, IV Infusion Therapy/P /Dx 1St To 1 Hr - (AED 40.0000) , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay

Doctor's Name: **Humaira** 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 and copies of all medical and Clinic records.

Signature of the Patient

Date **24-Apr-2024**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	5	5

Medicine	Dose	Duration	Quantity
(CAFFEINE : 60 MG) (PARACETAMOL : 500 MG) TABLETS	TABLETS (30S, BLISTER PACK)	5	10
(PANTOTHENIC ACID (VITAMIN B5) : 6 MG) (PHOSPHORUS : 125 MG) (CHOLECALCIFEROL : 400 IU) (RIBOFLAVINE (VITAMIN B2) : 1.6 MG) (BIOTIN : 100 MCG) (FOLIC ACID : 195 MCG) (THIAMINE (VITAMIN B1) : 1.4 MG) (PHYTONADIONE (VITAMIN K1) : 30 MCG) (PYRIDOXINE (VITAMIN B6) : 2 MG) (ASCORBIC ACID (VITAMIN C) : 60 MG) (VITAMIN A : 4000 IU) (VITAMIN E : 14.9 IU) (LUTEIN : 1000 MCG) (MOLYBDENUM : 50 MCG) (IRON (FERROUS FUMARATE) : 10 MG) (NIACINAMIDE : 18 MG) (VITAMIN B12 : 1 MCG) (SELENIUM (AS SODIUM SELENATE)	TABLETS (30S, PLASTIC BOTTLE)	30	30
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10