

**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: **13-Apr-2023**Clinic Name: **Irham Medical Center Arjan**Emirates: **784-1983-6048039-0**Card Holder's Name: **Atif Shakoor Muhammad Shakoor** Age: **39Y - 10M - 15D** Sex: **Male**

Card Holder's Tel No:

Mobile No:

0558358453Ins Card No: **I011-010-118184761-01**Valid Upto: **7/6/2023**Company **FMC NETWORK UAE**Name: **MANAGEMENT****CONSULTANCY**

Employee

No:

Nationality: **Pakistani**

Clinical Details:

Temp **36.9**B.P. **127**Pulse. **94**Signs & Symptoms: **Risk of Fall**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
Diagnosis: **I95.9 - Hypotension, unspecified**Management plan (Services inside the clinic including injections and investigations)

2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE-(DEXTROSE : 5% W/V) (SODIUM CHLORIDE : 0.45% W/V) SOLUTION , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: **Enomen Goodluck**

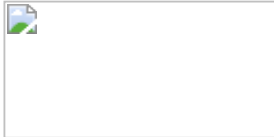
signature with seal:



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 any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **13-Apr-2023**

Pharmaceuticals (to be filled by treating doctor only)