ANNEXURE V

F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, P. O. BOX: 127452, ABU DHABI
Tel – 04 3977841, Fax – 04 3977842
Email – claims@fmchealthcare.ae **Toll Free: 800 3426**

Reimbursement Claim Form

Date : __/__/____.

Clinic /Hospital Name _____ Emirates _____

Card Holder's Name _____ Age _____ Sex : M ☐ F☐

Card Holder's Tel No _____ Mobile No _____

Ins. Card No _____ Valid up to____/ ____/____

Company Name _____Employee No _____ Nationality _____

Affix copy of front side of Insurance card

Clinical Details: Temp _____° C B.P. _____mmHg Pulse. _____/ min
Sign & Symptoms _____

_____Date of onset of illness:_____

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis _____

Management plan (Services inside the clinic including injections and investigations)
1)
2)
3)
4)
Doctor's Name and 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, or medical services and copies of all medical and Clinic records.

Date ____/_____/ _____ Signature of the Patient _____.

Pharmaceuticals (to be filled by treating doctor only)			**(To be filled by the pharmacy)**	
Trade Name	**Dose**	**Total Duration**	**Quantity**	**Price**
1)				
2)				
3)				
4)				
Please apply general exclusions			Total	

CLINIC	PHARMACY	DIAGNOSTIC CENTRE	HOSPITAL OR OTHER

Kindly tick whichever is applicable