ANNEXURE V

FMC NETWORK UAE (TPA)

HOSPITAL ONLY

Tel : 02-641 41 04 Fax : 02-641 88 78
24 Hrs Helpline Number: 600-565691, email : approval@fmchealthcare.ae

MEDICAL EXPENSES CLAIMS FORM
(FOR HOSPITAL ONLY)

Service	☐ OP ☐ IP	**Network**	OP : FMC NETWORK UAE ONLY IP : ☐ FMC / FMH Network ☐ _____

Provider Name		Emirates	
Membership / Card No.			
Ins. Company			

Patient's Name	
File / Record No.	
DOB / AGE/Sex	☐ M ☐ F
Nationality	
Contact No.	

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) _____

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)**	
Generic Name	**Dose**	**Duration**	**Quantity**	**Price**
1)				
2)				
3)				
4)				
Please apply general exclusions			Total	