



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

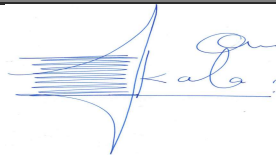
Medical Expenses Claim form

Date: **13-Jul-2024**

Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1998-3829071-8**
 Card Holder's Name: **Junaid Munirmunir Hussain** Age: **26Y - 0M - 25D** Sex: **Male**
 Card Holder's Tel No: Mobile No: **0509007485**
 Ins Card No: **I020-010-117681116-03** Valid Upto: **27/4/2025**
 Company **FMC Standard** Employee _____ Nationality: **Pakistani**
 Name: **Network** No: _____



Clinical Details:	Temp 37.5	B.P. 118	Pulse. 90
Signs & Symptoms: Risk of Fall			
Date of Onset Illness : _____		☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit	
Diagnosis: R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough			

Management plan (Services inside the clinic including injections and investigations)	
0095-107701-0801, (CEFTRIAXONE : 1000 MG) POWDER FOR INJECTION , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 3834-106618-1001, (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 9, Consultation Gp , General Consultation	
Doctor's Name: Enomen Goodluck	signature with seal:  Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.

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.

Signature of the Patient



Date 13-Jul-2024

A large rectangular box with a thin border, intended for the patient's signature.

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10	0.0000
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10	0.0000
CETIRIZINE HCL	Tablet	5	5	0.0000