

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:	ป5-Au	g-2024
-------	-------	--------

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-6969037-5 Card Holder's Name: MYA THAZIN KHINE Age: 29Y - 2M - 21D Sex: Female

Card Holder's Tel No: Mobile No: 0525146406
Ins Card No: 1019-010-115402222-01 Valid Upto: 7/6/2025

Company FMC Standard Employee

Name: Network No: Nationality: Myanmarese



🖹, Pharmacy,9,

Clinical Details:	Temp <mark>36.7</mark>	B.P.110	Pulse. 78
Signs & Symptoms: Risk of F	all		
Date of Onset Illness:		○ Emergency ○ Wor	k related O New visit O Follow
Diagnosis: A09 - Infectious	gastroenteritis and colitis, un	specified, R11.0 - Nausea, R10.13 - Ep	igastric pain

Management plan (Services inside the clinic including injections and investigations)

0005-174202-0781, RISEK 40MG-(OMEPRAZOLE: 40 MG) POWDER FOR INFUSION, Pharmacy,96372, THER/PROPH/DIAG INJ SCO.Pay,0005-136504-1021, SCOPINAL, Pharmacy,0135-149902-0512, (DICLOFENAC SODIUM: 75 MG/3ML) INJECTION, Pharm INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, Co.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, Co.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, Co.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, Co.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, Co.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION FOR INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.Pay,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.PAY,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.PAY,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.PAY,0135-116611-1001, (METRONIDAZOLE: 0.5%) SOLUTION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, CO.PAY,014

Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL: 10 MG/ Gp, General Consultation,96374, THER/PROPH/DIAG INJIV PUSH, Co.Pay

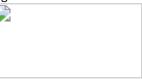
Doctor's Name: AHSAN HUSSAIN signature with seal:

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 at mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy c person who has provided medical services to me to furnish any and all information with regard to any medical history, medical comedical services and copies of all medical and Clinic records.

Signature of the Patient

Date 05-Aug-2024



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(CEFIXIME : 400 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (5S, BLISTER PACK)	7	7
(ESOMEPRAZOLE : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER PACK)	7	14
(METOCLOPRAMIDE : 10 MG) TABLETS	TABLETS (20S, BLISTER PACK)	3	9
(HYOSCINE: 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10

Medicine	Dose	Duration	Quan
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10