

**ANNEXURE V****F M C NETWORK UAE**

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842  
 Email – [approval@fmchealthcare.ae](mailto:approval@fmchealthcare.ae) Helpline Number: 600-565691

Medical Expenses Claim formDate: **09-Aug-2024**

Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1995-5770127-5**  
 Card Holder's Name: **ALBIN ANTONY RAJU** Age: **28Y - 8M - 2D** Sex: **Male**  
 Card Holder's Tel No: Mobile No: **0569618957**  
 Ins Card No: **I019-010-118700760-01** Valid Upto: **7/6/2025**  
 Company Name: **FMC Standard Network** Employee No: \_\_\_\_\_ Nationality: **Indian**



Clinical Details: Temp **39.6** B.P. **150** Pulse. **102**  
 Signs & Symptoms: **RISK FOR FALL**  
 Date of Onset Illness : \_\_\_\_\_ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up  
 Diagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], R05 - Cough, M79.10 - Myalgia, unspecified site**

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

**9, Consultation Gp , General Consultation, 2190-106618-1001, (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 174202-0781, RISEK 40MG , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 96372, THER/PRO INJ SC/IM , Co.Pay, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay, 0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER**

Doctor's Name: **Enomen Goodluck**

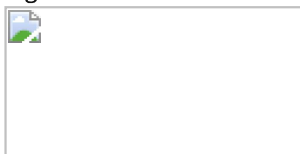
signature with seal:

**Dr. Enomen Goodluck I**  
 General Practitioner  
 DHA No: 28040827-00  
**CITICARE MEDICAL CENTRE**  
 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 a person who has provided medical services to me to furnish any and all information with regard to any medical history, medical conditions and medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **09-Aug-2024**Pharmaceuticals (to be filled by treating doctor only)

| Medicine       | Dose   | Duration | Quantity |
|----------------|--------|----------|----------|
| CETIRIZINE HCL | Tablet | 5        | 5        |

| Medicine                                                                                                                                                                                                                                                                    | Dose                         | Duration | Quantity |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------|----------|
| (CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET                                                                                                                                                                                | CAPLET-TABLET (30S, BLISTER) | 7        | 14       |
| (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS                                                                                                                                                                                                                   | TABLETS (14S, BLISTER PACK)  | 7        | 14       |
| (ADHATODA VASICA : 112.5 MG/10ML) (TULSI (OCIMUM SANCTUM) : 90MG/10ML) (SOLANUM XANTHOCARPUM : 90MG/10ML) (TERMINALIA BELLIRICA EXTRACT : 52.5 MG/10ML) (HEDYCHIUM SPICATUM : 37.5 MG/10ML) (GLYCYRRHIZA GLABRA EXTRACT : 22.5 MG/10ML) (PIPER LONGUM : 22.5 MG/10ML) SYRUP | SYRUP (200ML, BOTTLE)        | 5        | 10       |