

**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 formDate: **22-Aug-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1980-8988062-3**Card Holder's Name: **RATTANEE PANATEE** Age: **44Y - 0M - 4D** Sex: **Female**Card Holder's Tel No: Mobile No: **0506223810**Ins Card No: **I017-010-120072719-01** Valid Upto: **7/11/2024**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Thai**

Clinical Details: Temp **36.5** B.P. **114** Pulse: **78**
Signs & Symptoms: **RISK FOR FALL**
Date of Onset Illness : _____
☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
Diagnosis: **R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, K13.0 - Diseases of liver**

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION NEBULIZATION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,9, Co.

Doctor's Name: **Humaira**

signature with seal:

Dr. Humaira M
General Practitioner
DHA No: 541555
CITICARE MEDICAL C
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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **22-Aug-2024**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	7

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	7
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) GASTRO-RESISTANT TABLETS	GASTRO-RESISTANT TABLETS (14S, BLISTER)	7	14
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	1	1
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12