

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.	22-1	Aug-2024
Date.	ZZ-F	1ug-2024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1976-7142626-6 Card Holder's Name: YANISA PONGKULARB Age: 48Y - 0M - 30D Sex: Female

Card Holder's Tel No: 0545562899 Mobile No: Ins Card No: 1017-010-118716766-01 Valid Upto: 7/11/2024 Company Name: FMC Standard Network Employee No: Nationality: Thai



Clinical Details:	Temp <mark>36.9</mark>	B.P. <mark>90</mark>	Pulse. <mark>76</mark>
Signs & Symptoms: RISK	FOR FALL		
Date of Onset Illness :		Emergency Work	related O New visit O Follow
Diagnosis: R50.9 - Fever	, unspecified, J06.9 - Acute uppe	er respiratory infection, unspecified, R05	5 - Cough

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,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER, INJ SC/IM, Co.Pay,9, Consultation Gp, General Consultation

signature with seal:

Dr. Humaira M General Practiti DHA No: 541555 CITICARE MEDICAL C

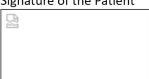
Diagnostic Procedures referred outside:

Doctor's Name: Humaira

l hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the a 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 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	Quan
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5

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Medicine	Dose	Duration	Quant
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	7
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	1	1
(ORAL REHYDRATION SALTS (O.R.S.): N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (50S, SACHET)	5	5

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