

## 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

7/6/2025

Valid Upto:

Date: 30-Aug-2024						
Clinic Name: CITICARE MED	DICAL CENTER LLC	Em	irates:	784-2001-	13401	71-3
Card Holder's Name:	Dipesh Limbu	Age:	0Y - 5N	√ - 12D	Sex:	Mal
Card Holder's Tel No:	Mobile	No:		05678842	71	

1019-010-120042277-01 **FMC Standard** Company **Employee** 

Name: Network No:

Ins Card No:



Clinical Details:	Temp <mark>38</mark>	B.P.112	Pulse. <mark>84</mark>
Signs & Symptoms: RISK	FOR FALL		
Date of Onset Illness :		○ Emergency ○ Wo	ork related O New visit O Follow up visit
Diagnosis: R50.9 - Fever	, unspecified, J06.9 - Acute upp	er respiratory infection, unspecified,	J02.9 - Acute pharyngitis, unspecified, R05 -
Cough, K29.00 - Acute g	astritis without bleeding		

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,9,

Consultation Gp , General Consultation

Doctor's Name: Humaira signature with seal:

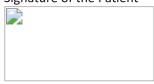
Dr. Humaira Mumtaz **General Practitioner** DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.

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 abovementioned 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 30-Aug-2024



## Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	7	0.0000
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10	0.0000
(AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP	SYRUP (120ML, GLASS BOTTLE)	1	1	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14	0.0000