



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: **30-Aug-2024**

Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-2001-1340171-3**

Card Holder's Name: **Dipesh Limbu** Age: **0Y - 5M - 12D** Sex: **Male**

Card Holder's Tel No: Mobile No: **0567884271**

Ins Card No: **I019-010-120042277-01** Valid Upto: **7/6/2025**

Company **FMC Standard** Employee _____ Nationality: **Nepalese**
Name: **Network** No:



Clinical Details: Temp **38**

B.P. **112**

Pulse. **84**

Signs & Symptoms: **RISK FOR FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis: **R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified, J02.9 - Acute pharyngitis, unspecified, R05 - Cough, K29.00 - Acute gastritis 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 above-mentioned 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