

**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: **06-Sep-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1983-7397594-9**Card Holder's Name: **JUDILYN TORRES DELA ROSA** Age: **41Y - 2M - 20D** Sex: **Female**

Card Holder's Tel No:

Mobile No:

0503281217Ins Card No: **I019-010-118489752-01**Valid Upto: **8/6/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Philippine**

Clinical Details:

Temp **37.3**B.P. **178**Pulse. **86**Signs & Symptoms: **RISK FOR FALL**

Date of Onset Illness :

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

Diagnosis: **G43.009 - Migraine w/o aura, not intractable, w/o status migrainosus, K29.00 - Acute gastritis without bleeding, R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified**

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

9, Consultation Gp , General Consultation, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0005-149902-1021, CLOFEN , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy

Doctor's Name: **Enomen Goodluck**

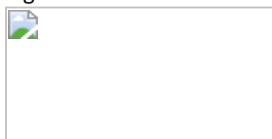
signature with seal:

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
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 **06-Sep-2024**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (30S, SACHET)	4	16	0.0000
(SUMATRIPTAN (AS SUCCINATE) : 100 MG) FILM COATED TABLETS	FILM COATED TABLETS (2S, BLISTER PACK)	5	5	0.0000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10	0.0000
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	6	6	0.0000