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: 07-Sep-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-4084820-5
Card Holder's Name: SRIDHAR THOKALA THOKALA BHUMANNA Age: 24Y - 8M - 26D Sex: Male
Card Holder's Tel No: Mobile No: 0567915743
Ins Card No: 784-1999-4084820-5 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp37.8 B.P.122 Pulse. 86
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J03.90 - Acute tonsillitis, unspecified, R50.9 - Fever, unspecified Allergic rhinitis, unspecified, J20.9 - Acute bronchitis, unspecified, R06.00 - Dyspnea, 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 , Pharmac 107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0125 1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,94640, A INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT , Pharmacy

Doctor's Name: Enomen Goodluck signature with seal:

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 ab mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy c person who has provided medical services to me to furnish any and all information with regard to any medical history, medical c medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 07-Sep-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	5	15
(AZITHROMYCIN : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	5
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	10	10

Medicine	Dose	Duration	Quant
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10