

ANNEXURE V

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.	. 07-3ep	-2024
Clinic	Name:	CITIO

Ins Card No:

CARE MEDICAL CENTER LLC Emirates: 784-1999-4084820-5 SRIDHAR THOKALA THOKALA Card Holder's 24Y - 8M -

Name: **BHUMANNA**

Card Holder's Tel No: 0567915743 Mobile 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: \bigcirc Emergency \bigcirc Work related \bigcirc New visit \bigcirc 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

Dr. Enomen Goodl **General Practiti** DHA No: 280408 CITICARE MEDICAL C DUBAI - U.A

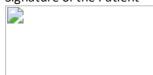
Doctor's Name: Enomen Goodluck signature with seal:

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 at 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 co 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	Quan
(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	Quan
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10