

ANNEXURE V

C NETWORK UAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842 Email - approval@fmchealthcare.ae Helpline Number: 600-565691

Medical	<u>Expenses</u>	Claim	form

7/6/2025

Nationality: Philippine

Emirates: 784-1990-0303086-5

Date: 08-Sep-2024	
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Clinic Name: CITICARE MEDICAL CENTER LLC Card Holder's JOANNA MARIE ESTADILLA

Name: **CORTES**

Card Holder's Tel No: Mobile No: Ins Card No:

1019-010-116775829-01 Company **FMC Standard Employee**

Name: Network No:



Clinical Details: B.P.168 Pulse. 86 Temp37

Valid Upto:

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness: ○ Emergency ○ Work related ○ New visit ○ Follow up

Diagnosis: R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified, I10 - Essential (primary) hypertension

Headache, unspecified

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

0135-149902-0511, (DICLOFENAC SODIUM : 75 MG/3ML) INJECTION , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , 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

Dr. Humaira Mumta **General Practitioner** DHA No: 54155530-00 CITICARE MEDICAL CENTE DUBAI - U.A.E

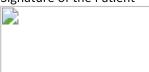
Doctor's Name: Humaira signature with seal:

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

Signature of the Patient

Date 08-Sep-2024



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	TABLETS (30S, BLISTER)	30	30

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	25
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	7
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	1	1