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

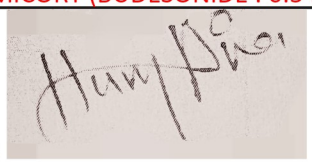
Date: 26-Sep-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1990-5991290-9
Card Holder's Name: FURAHA NTIBINCAKO Age: 51Y - 3M - 28D Sex: Female
Card Holder's Tel No: Mobile No: 0544677778
Ins Card No: I005-010-116700145-02 Valid Upto: 6/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Jordanian

Clinical Details: Temp37.2 B.P.103 Pulse. 60
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, M62.830 - Muscle sp
K29.00 - Acute gastritis without bleeding, J30.9 - Allergic rhinitis, unspecified

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

9, Consultation Gp , General Consultation,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96365, IV INFUSION THERA
PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJ
Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPEN
NEBULIZATION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay

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

Signature of the Patient

Date 26-Sep-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant

Medicine	Dose	Duration	Quant
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5
(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
TOLPERISONE HCL	Tablet	5	10
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	1	1
(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (100G, TUBE)	1	1