

**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: **28-Sep-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1997-7509331-5**Card Holder's Name: **RUKSHAN BANDARA**Age: **27Y - 7M - 23D** Sex: **Male**

Card Holder's Tel No:

Mobile No:

0502214781Ins Card No: **I019-010-118700500-01**Valid Upto: **7/6/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Sri Lankan**

Clinical Details:

Temp **37.4**B.P. **125**Pulse. **77**Signs & Symptoms: **risk of fall**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], M54.5 - Low back pain, S62.0 - Fracture of scaphoid, K21.9 - Gastro-esophageal reflux disease without esophagitis**

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 174202-0781, RISEK 40MG , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM Co.Pay, 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION INHALATION TREATMENT , Co.Pay, 9, Consultation Gp , General Consultation

Dr. Ahsan Hussain
 General Practitioner
 DHA No: 87543658-001
CITICARE MEDICAL CENTER
 DUBAI - U.A.E.

Doctor's Name: **AHSAN HUSSAIN**

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 condition, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **28-Sep-2024**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
CETIRIZINE HCL	Tablet	5	5

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	7	1