

**ANNEXURE V****F M C NETWORK UAE**

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Medical Expenses Claim formDate: **28-Sep-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1995-8162758-7**Card Holder's Name: **LOKNATH SHARMA KUL PRASAD UPADHYAYA** Age: **28Y - 10M - 21D** Sex: **Male**Card Holder's Tel No: Mobile No: **971564645688**Ins Card No: **I019-010-119489092-01** Valid Upto: **7/6/2025**Company Name: **FMC Standard Network** Employee No: Nationality: **Nepalese**Clinical Details: Temp **37.3** B.P. **125** Pulse. **96**Signs & Symptoms: **risk of fall**Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], M54.5 - Low back pain, 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, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML SOLUTION FOR INFUSION , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 0005-174202-0781 40MG , Pharmacy, 94640, AIRWAY INHALATION TREATMENT , Co.Pay, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 9, Consultation Gp , General Co.Pay

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