

## ANNEXURE V O 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

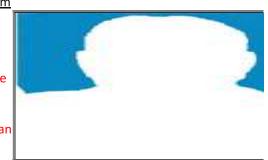
Date: 30-Sep-2024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1989-7357800-2 Card Holder's Name: GIUSEPPE MANZELLA Age: 35Y - 6M - 6D Sex: Male

 Card Holder's Tel No:
 Mobile No:
 0521067321

 Ins Card No:
 I017-010-120097457-01
 Valid Upto:
 2/5/2025

Company Name: FMC Standard Network Employee No: \_\_\_\_\_\_Nationality: Italian



Clinical Details:	Temp <mark>37.5</mark>	B.P. <mark>128</mark>	Pulse. <mark>90</mark>
Signs & Symptoms: RISK (	OF FALL		
Date of Onset Illness:		○ Emergency ○ Work re	elated O New visit O Follow up
Diagnosis: J11.1 - Flu due	to unidentified influenza virus v	w oth resp manifest, J03.90 - Acute tons	sillitis, unspecified, J20.9 - Acute I
unspecified, R50.9 - Fever	unspecified		

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

96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR, Co.Pay,0195-107704-0801, CEFTRIAXONE-TABUK IV, Pharmacy,000 149902-1021, CLOFEN, Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, Pharmacy,2190-106618-1001, PAI.V. 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION FOR INFUSION, Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM, Co.Pay,9,

Consultation Gp , General Consultation

signature with seal:

Dr. Enomen Goodluck I
General Practitioner
DHA No: 28040827-00
CITICARE MEDICAL CENTE
DUBAI - U.A.E.

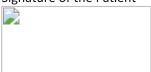
Diagnostic Procedures referred outside:

Doctor's Name: Enomen Goodluck

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the abore 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 cormedical services and copies of all medical and Clinic records.

Signature of the Patient

Date 30-Sep-2024



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(POVIDONE IODINE : 0.45%) SPRAY SOLUTION	SPRAY SOLUTION (50ML, BOTTLE)	7	1
(OSELTAMIVIR (AS PHOSPHATE) : 75 MG) CAPSULES	CAPSULES (10S, BLISTER)	10	10

Medicine	Dose	Duration	Quantity
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	5
(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER)	4	16
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5