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: 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: Temp37.5 B.P.128 Pulse. 90
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J11.1 - Flu due to unidentified influenza virus w oth resp manifest, J03.90 - Acute tonsillitis, unspecified, J20.9 - Acute b 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, PA
I.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

Doctor's Name: Enomen Goodluck signature with seal:

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

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 abo 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 co medical 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