

ANNEXURE V I 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: 1	13-O	ct-2	024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-6135536-5 Card Holder's Name: YAKUWA SARU MAGAR Age: 28Y - 11M - 2D Sex: Male

Card Holder's Tel No: Mobile No: 0529099626
Ins Card No: 1019-010-119026412-01 Valid Upto: 7/6/2025

Company FMC Standard Employee

Name: Network No: Nationality:Nepalese



Clinical Details:	Temp	B.P.	Pulse.
Signs & Symptoms:			
Date of Onset Illness :		○ Emergency ○) Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upp	er respiratory infection, u	nspecified, J30.9 - Allergic rhinitis,	unspecified, R50.9 - Fever, unspecified, K
Acute gastritis without blee	ding, R05 - Cough		

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FO INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FO INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,1393-135904-2441, (BUDESONIDE : 0

MG/2ML) SUSPENSION FOR NEBULIZATION, Pharmacy,0195-107704-0801, CEFTR DEXAMETHASONE: 4 MG/ML) SOLUTIO THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR, Co.Pay,96372, THER/PROPH/DIAG INJ SOLUTION (BUDESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, Pharmacy,94640, A CHOCKOKÍS NAME: HIMMAITA SIGNATURE WITH SEAL:

Harry Pino

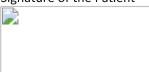
Dr. Humaira Mumta General Practitioner DHA No: 54155530-00 CITICARE MEDICAL CENTE DUBAI - U.A.E.

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 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 13-Oct-2024



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	1

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	1	1