

**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: **13-Oct-2024**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:

0529099626Ins Card No: **I019-010-119026412-01**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 upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, K72.0 - Acute gastritis without bleeding, 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) SOLU INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,1393-135904-2441, (BUDESONIDE : 0.5 MG/2ML) SUSPENSION FOR NEBULIZATION , Pharmacy,0195-107704-0801, CEFTRIAXONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,94640, A (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, A

Doctor's Name: **Humaira**

signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTRE
 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 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 **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