

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

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842  
 Email – [approval@fmchealthcare.ae](mailto:approval@fmchealthcare.ae) Helpline Number: 600-565691

Medical Expenses Claim formDate: **14-Oct-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1993-2349359-5**Card Holder's Name: **Richard Ruhimbaza** Age: **31Y - 6M - 28D** Sex: **Male**Card Holder's Tel No: Mobile No: **0547432954**Ins Card No: **I019-010-120688121-01** Valid Upto: **7/6/2025**Company **FMC Standard** Employee \_\_\_\_\_ Nationality: **Rwandan**  
 Name: **Network** No:Clinical Details: Temp **36.8** B.P. **144** Pulse. **92**Signs & Symptoms: **RISK FOR 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, R10.13 - Epigastric pain, R05 - Cough, J20.9 - Acute bronchitis, unspecified**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 500MG/ML) SOLUTION FOR INFUSION , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 174202-0781, RISEK 40MG , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96365, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 9, Consultation Gp , General Consultation**

Doctor's Name: **AHSAN HUSSAIN**

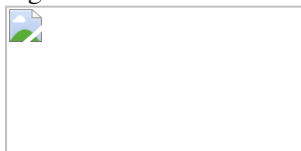
signature with seal:

**Dr. Ahsan Hussain**  
 General Practitioner  
 DHA No: 8754365  
**CITICARE MEDICAL CENTER**  
 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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **14-Oct-2024**Pharmaceuticals (to be filled by treating doctor only)

| Medicine                                                                                       | Dose                                    | Duration | Quantity |
|------------------------------------------------------------------------------------------------|-----------------------------------------|----------|----------|
| (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS                                                   | FILM COATED TABLETS (10S, BLISTER PACK) | 5        | 5        |
| (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       |

