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: 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 Name: FMC Standard Network Employee No: _____Nationality:Rwandan

Clinical Details: Temp36.8 B.P.144 Pulse. 92
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], M54.5 - Low ba
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-(PARACETA
MG/ML) SOLUTION FOR INFUSION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Phar
174202-0781, RISEK 40MG , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,963
THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultati

Doctor's Name: AHSAN HUSSAIN signature with seal:

Dr. Ahsan Hus
General Practiti
DHA No: 8754365
CITICARE MEDICAL C
DUBAI - U.A.

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 a
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
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	Quant
(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