**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: 784-1984-3969292-6
Card Holder's Name: KRIS CRISTOPHER GIMENO ROMA Age:39Y - 9M - 24D Sex:Male
Card Holder's Tel No: Mobile No: 0503413891
Ins Card No: I019-010-116735896-01 Valid Upto: 19/1/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Philippine

Clinical Details: Temp37.3 B.P.140 Pulse. 92
Signs & Symptoms: RISK OF FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: J20.9 - Acute bronchitis, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough

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

9, Consultation Gp , General Consultation,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,96365, IV IN THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay

Dr. Enomen Goodl
General Practiti
DHA No: 280408
CITICARE MEDICAL C
DUBAI - U.A.

Doctor's Name: Enomen Goodluck signature with seal:

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) | 10 | 10 |

| Medicine | Dose | Duration | Quant |
|---|---|---|---|
| (PREDNISOLONE : 5 MG) TABLETS | TABLETS (20S, BLISTER PACK) | 7 | 14 |
| (AZITHROMYCIN : 500 MG) FILM COATED TABLETS | FILM COATED TABLETS (6S, BLISTER) | 5 | 5 |
| (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP | SYRUP (200ML, BOTTLE) | 7 | 1 |
| (DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS | FILM COATED TABLETS (20S, BLISTER PACK) | 10 | 20 |