

**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: **19-Oct-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1999-1045903-3**Card Holder's Name: **MEHDI TAZOUTI**Age: **25Y - 1M - 3D** Sex: **Male**Card Holder's Tel No: Mobile No: **+212678613731**Ins Card No: **I019-010-120692323-01**Valid Upto: **7/6/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Moroccan**

Clinical Details:

Temp **36.5**B.P. **110**Pulse. **58**Signs & Symptoms: **RISK FOR FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], R05 - Cough, J30.9 - rhinitis, unspecified, M54.5 - Low back pain**

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 : 10 MG/ML SOLUTION FOR INFUSION , Pharmacy,1393-135904-2441, (BUDESONIDE : 0.5 MG/2ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pa THER/PROPH/DIAG INJ SC/IM , Co.Pay,0125-122107-1022, DEXAMETHASONE SOD

Consultation

Dr. Ahsan Hussain
 General Practitioner
 DHA No: 87543658-001
CITICARE MEDICAL CENTER
 DUBAI - U.A.E.

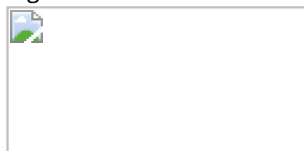
Doctor's Name: **AHSAN HUSSAIN**

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 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 conditions, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **19-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)	7	7

Medicine	Dose	Duration	Quantity
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	7	1
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14