

**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: **21-Oct-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1998-8210760-2**Card Holder's Name: **SIDHARTH RAVEENDRAN EDONIMMAL RAVEENDRAN** Age: **25Y - 10M - 6D** Sex: **Male**Card Holder's Tel No: Mobile No: **0553049284**Ins Card No: **I019-010-118678031-01** Valid Upto: **7/6/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**Clinical Details: Temp **36.6** B.P. **98** Pulse. **58**Signs & Symptoms: **RISK FOR FALL**Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **A09 - Infectious gastroenteritis and colitis, unspecified, R11.10 - Vomiting, unspecified, R19.7 - Diarrhea, unspecified, E Dehydration, R50.9 - Fever, unspecified**Management plan (Services inside the clinic including injections and investigations)

9, Consultation Gp , General Consultation, 0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy, 0102-111908-1001, SODIUM CL B.P. , Pharmacy, 0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy, 0148-1 1001, (METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /Dx HR , Co.Pay, 96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay, 96360, HYDRATION IV

Doctor's Name: **Humaira**

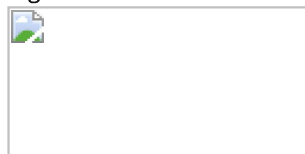
signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTE
 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 **21-Oct-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(CEFIXIME : 400 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (5S, BLISTER)	7	7

Medicine	Dose	Duration	Quantity
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14
(SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (12S, BLISTER)	7	21
(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (28.5G X 10, SACHET)	5	5