

ANNEXURE V

FMCNETWORK 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: 23-Oct-2024

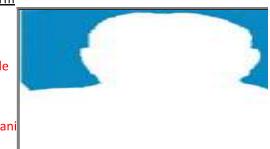
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1994-2299080-6 Card Holder's Name: ADNAN YAQOOB Age: 30Y - 3M - 19D Sex: Male

Card Holder's Tel No: Mobile No: 0566465723

Ins Card No: 1019-010-118915814-01 Valid Unto: 7/6/2025

Ins Card No: 1019-010-118915814-01 Valid Upto: 7/6/2025

Company FMC Standard Employee
Name: Network No: Nationality:Pakistani



Clinical Details:	Temp37	B.P. 130	Pulse. 86

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

© Emergency © Work related © New visit © Follow up

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, T78.40XS - Allergy, unspecified, sequela, R05 - Cough, K29.00 - A

gastritis without bleeding, R50.9 - Fever, unspecified

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

0195-107704-0801, CEFTRIAXONE-TABUK IV, Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 HR, Co.Pay,000 149902-1021, CLOFEN -(DICLOFENAC SODIUM: 75 MG/3ML) SOLUTION FOR INJECTION, Pharmacy,96372, THER/PROPH/DIAG IN Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, Pharmacy,94640, AIRWAY

INHALATION TREATMENT, Co.Pay,9, Consultation Gp, General Consultation

Ham/ Piro

Dr. Humaira Mumta General Practitioner DHA No: 54155530-00 CITICARE MEDICAL CENTE DUBAI - U.A.E.

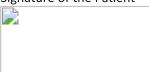
Doctor's Name: Humaira signature with seal:

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 abore 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 cormedical services and copies of all medical and Clinic records.

Signature of the Patient

Date 23-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
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER)	7	7

Medicine	Dose	Duration	Quantity
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	1	1
(BETAMETHASONE : 0.1%) CREAM	CREAM (30G, TUBE)	1	1