

**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: **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: **I019-010-118915814-01**Valid Upto: **7/6/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Pakistani**

Clinical Details:

Temp **37**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 - Acid 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**

Doctor's Name: **Humaira**

signature with seal:

Dr. Humaira Mumtaz
 General Practitioner
 DHA No: 54155530-00
CITICARE MEDICAL CENTRE
 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 **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