

**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: **05-Nov-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-2004-4675351-7**Card Holder's Name: **SABRINA LAZARUS** Age: **20Y - 5M - 2D** Sex: **Female**Card Holder's Tel No: Mobile No: **0553059518**Ins Card No: **I005-010-119843974-01** Valid Upto: **30/9/2025**Company **FMC Standard** Employee
 Name: **Network** No: _____ Nationality: **Indonesian**Clinical Details: Temp **36.8** B.P. **100** Pulse. **88**Signs & Symptoms: **RISK FOR FALL**Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R52 - Pain, unspecified**Management plan (Services inside the clinic including injections and investigations)

9, Consultation Gp , General Consultation, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 010801, CEFTRIAXONE-TABUK IV , Pharmacy, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Doctor's Name: **Humaira**

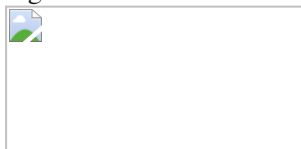
signature with seal:

Dr. Humaira N
 General Practitioner
 DHA No: 541551
CITICARE MEDICAL
 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 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 services and copies of all medical and Clinic records.

Signature of the Patient

Date **05-Nov-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CEFIXIME : 400 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (6S, BLISTER PACK)	7	7
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	3	6
(AZITHROMYCIN : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER	7	7

Medicine	Dose	Duration	Quanti
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES	DELAYED RELEASE CAPSULES (30S, CONTAINER	7	7