

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

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Date:	na n	01/	กวน
Date.	ひコーハ	IUV-2	UZ4

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-5770127-5
Card Holder's Name: ALBIN ANTONY RAJU Age: 28Y - 11M - 2D Sex: Male

Card Holder's Tel No: Mobile No: 0569618957
Ins Card No: 1019-010-118700760-01 Valid Upto: 7/6/2025

Company Name: FMC Standard Network Employee No: ______Nationality: Indian



Clinical Details:	Temp <mark>37</mark>	B.P. <mark>124</mark>	Pulse. <mark>82</mark>
Signs & Symptoms: RIS	SK FOR FALL		
Date of Onset Illness:		○ Emergency ○ Wo	ork related O New visit O Follow up
Diagnosis: K29.00 - Ac	ute gastritis without blee	ding, R11.11 - Vomiting without nausea, R19	.7 - Diarrhea, unspecified, K21.9 - Gas

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

esophageal reflux disease without esophagitis, R10.13 - Epigastric pain, E86.0 - Dehydration

0131-116601-1001, (METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION , Pharmacy,0005-174202-0781, RISEK 40MG , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0265 1021, (METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX

HR, Co.Pay,96360, HYDRATION IV INFUSION INIT, Co.Pay,9, Consultation Gp, Gen. Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH, Co.Pay

Doctor's Name: AHSAN HUSSAIN signature with seal:

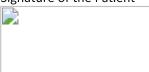
Dr. Ahsan Hussain General Practitioner DHA NO: 87543658-001 CITICARE MEDICAL CENTER DUBAI - U.A.E,

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 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 09-Nov-2024



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(METRONIDAZOLE : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK	7	14

Medicine	Dose	Duration	Quantity
(METOCLOPRAMIDE : 10 MG TABLETS	TABLETS (20S, BLISTER PACK	5	10
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	CAPSULES (HARD GELATIN (14S, BLISTER	5	10
(SIMETHICONE : 250 MG) CAPSULES	CAPSULES (30S, BLISTER)	5	10
(HYOSCINE : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (200S, BLISTER PACK)	5	10