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 form

Date: 09-Nov-2024
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: I019-010-118700760-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp37 B.P.124 Pulse. 82
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: K29.00 - Acute gastritis without bleeding, R11.11 - Vomiting without nausea, R19.7 - Diarrhea, unspecified, K21.9 - Gas esophageal reflux disease without esophagitis, R10.13 - Epigastric pain, E86.0 - Dehydration

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

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

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

Doctor's Name: AHSAN HUSSAIN 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 abo 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 co medical 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