

**ANNEXURE V****F M C NETWORK UAE**

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 Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim formDate: **11-Nov-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1998-8482131-7**Card Holder's Name: **KHARAK SINGH KISHAN SINGH** Age: **26Y - 3M - 27D** Sex: **Male**Card Holder's Tel No: Mobile No: **0569469783**Ins Card No: **I005-010-119076401-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**Clinical Details: Temp **36.8** B.P. **90** Pulse. **88**Signs & Symptoms: **RISK FOR FALL**Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, K29.00 - Acute gastritis without bleeding**Management plan (Services inside the clinic including injections and investigations)

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLU INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IN Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0102-111908-1001, SODIUM CHLORIDE B.P.-(SO Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,9, Consultation Gp , Gene

Doctor's Name: **Humaira**

signature with seal:

Dr. Humaira Mumta
 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 **11-Nov-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5

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
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES	DELAYED RELEASE CAPSULES (30S, CONTAINER	7	14
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	1	1