

## 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:	TT-I/IOA-	2024
Clinic	Name:	CITI

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: 1005-010-119076401-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Naturals Employee No: Nationality and

Company Name: FMC Standard Network Employee No: \_\_\_\_\_\_Nationality: Indian



Clinical Details:	Temp <mark>36.8</mark>	B.P. <mark>90</mark>	Pulse. <mark>88</mark>	
Signs & Symptoms: RISK Fo	OR FALL			
Date of Onset Illness:		$\bigcirc$ Emergency $\bigcirc$ Work related $\bigcirc$ New visit $\bigcirc$ Follow (		
,	oper respiratory infection, un e gastritis without bleeding	specified, J30.9 - Allergic rhinitis, un	specified, R05 - Cough, R50.9 - Fever,	

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

Hunthro

Dr. Humaira Mumta General Practitioner DHA No: 54155530-00: CITICARE MEDICAL CENTE DUBAI - U.A.E.

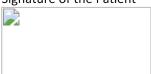
Doctor's Name: Humaira signature with seal:

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 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 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