

## 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: 1	1 4L-IN	INV- /	пи
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Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-9372048-6 Card Holder's Name: ADEDOYIN DEBORAH ODUNTAN Age: 28Y - 0M - 14D Sex: Female

 Card Holder's Tel No:
 Mobile No:
 524383857

 Ins Card No:
 1019-010-116854773-01
 Valid Upto:
 7/6/2025

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



Clinical Details:	Temp <mark>36.5</mark>	B.P. <b>110</b>	Pulse. <mark>86</mark>
Signs & Symptoms: risk o	f fall		
Date of Onset Illness :		○ Emergency ○ W	/ork related O New visit O Follow up
Diagnosis: J06.9 - Acute (	upper respiratory infection, unsp	pecified, J30.9 - Allergic rhinitis, un	specified, R50.9 - Fever, unspecified, R
Cough, K29.00 - Acute ga	stritis without bleeding		
Management plan (Ser	vices inside the clinic including i	njections and investigations)	

9, Consultation Gp , General Consultation,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION F INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML)

SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRWAY INHALATION TREATM

signature with seal:

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

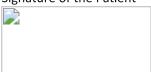
Diagnostic Procedures referred outside:

Doctor's Name: Humaira

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 con medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 14-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
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	7
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES	DELAYED RELEASE CAPSULES (30S, CONTAINER)	7	14