

## F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842 Email – approval@fmchealthcare.ae Helpline Number: 600-565691

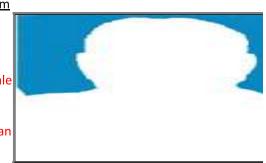
Medical Expenses Claim form

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Date: 1	L / - IN	IOV-2	024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-3269295-2 Card Holder's Name: PRIYANKA RAWAT DARBAN SINGH Age: 28Y - 9M - 7DSex: Female

Card Holder's Tel No: Mobile No: 0561479268
Ins Card No: 1019-010-117392367-01 Valid Upto: 7/6/2025

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



Clinical Details:	Temp <mark>36.6</mark>	B.P.110	Pulse. <mark>88</mark>
Signs & Symptoms: RISK FC	OR FALL		
Date of Onset Illness:		○ Emergency ○ W	ork related O New visit O Follow up

Diagnosis: L23.89 - Allergic contact dermatitis due to other agents, C84.09 - Mycosis fungoides, extranodal and solid organ sites, L
Dermatitis, unspecified, R21 - Rash and other nonspecific skin eruption, S80.822A - Blister (nonthermal), left lower leg, initial enco

R50.9 - Fever, unspecified

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

0005-111805-1021, CHLOROHISTOL 10MG, Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM, Co.Pay,9, Consultation Gp, General Consultation



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

Doctor's Name: AHSAN HUSSAIN

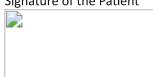
signature with seal:

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 aborentioned 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 conmedical services and copies of all medical and Clinic records.

Signature of the Patient

Date 17-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)	10	10

Medicine	Dose	Duration	Quantity
(CLOBETASOL PROPIONATE : 0.5 MG/G) CREAM	CREAM (30G, COLLAPSIBLE TUBE)	14	1
(AZITHROMYCIN : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER PACK	7	7