

**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 formDate: **22-Nov-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1985-4874694-4**Card Holder's Name: **SADAF NADEEM NADEEM YOUSAF** Age: **39Y - 9M - 2D** Sex: **Female**Card Holder's Tel No: Mobile No: **0508946099**Ins Card No: **I017-010-121098524-01** Valid Upto: **31/5/2025**Company **FMC Standard** Employee _____ Nationality: **Pakistani**Name: **Network** No: _____Clinical Details: Temp **37** B.P. **140** 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,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,000
149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG IN
Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRWAY
INHALATION TREATMENT , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: **Humaira**

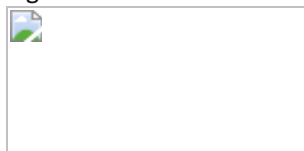
signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTE
 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 **22-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
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12

Medicine	Dose	Duration	Quantity
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1