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 form

Date: 23-Nov-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-6155272-9
Card Holder's Name: SUMANTA DAMAI BILASH DAMAI Age: 26Y - 10M - 22D Sex: Female
Card Holder's Tel No: Mobile No: 0585818611
Ins Card No: I019-010-121177968-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 36 B.P. 100 Pulse. 86
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], J20.9 - Acute br unspecified, R50.9 - Fever, unspecified, K21.9 - Gastro-esophageal reflux disease without esophagitis, R11.2 - Nausea with vo unspecified, E86.0 - Dehydration

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

0095-107701-0801, (CEFTRIAXONE : 1000 MG) POWDER FOR INJECTION , Pharmacy,2190-106618-1001, PARAFUSIV 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0265-150403-1021, (METOCLOPRA MG/2ML) SOLUTION FOR INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-136504-1021, SCOPINAL , Pharmacy,0188-135906-2441, PULMI TREATMENT , Co.Pay,82948, REAGENT STRIP/BLOOD GLUCOSE , Lab,010 B.P. , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.Pay,9, Consultation Gp , G

Doctor's Name: AHSAN HUSSAIN signature with seal:

Dr. Ahsan Hus
General Practiti
DHA No: 8754365
CITICARE MEDICAL C
DUBAI - U.A.

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 a mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medical medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 23-Nov-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	7
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14

Medicine	Dose	Duration	Quant
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP	SYRUP (200ML, BOTTLE	7	1
(ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS	FILM COATED TABLETS (28S, BLISTER PACK)	7	7