

**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: **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 - 25D**Sex: **Female**

Card Holder's Tel No:

Mobile No:

0585818611Ins Card No: **I019-010-121177968-01**Valid Upto: **7/6/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**

Clinical Details:

Temp **38**B.P. **100**Pulse. **86**Signs & Symptoms: **risk of fall**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J20.9 - Acute bronchitis, unspecified, R50.9 - Fever, unspecified, Gastro-esophageal reflux disease without esophagitis, R11.2 - Nausea with vomiting, 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 I.V. 10MG (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0265-150403-1021, (METOCLOPRAMIDE : 10 MG/2ML) SC INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-136504-1021, SCOPINAL Pharmacy,0188-135906-2441, PULMICORT , Pharmacy,94640, AIRWAY INHALATION, GLUCOSE , Lab,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy, TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96360, HYDRATION

Consultation

Doctor's Name: **AHSAN HUSSAIN**

signature with seal:

Dr. Ahsan Hussain
 General Practitioner
 DHA No: 8754365
CITICARE MEDICAL CENTER
 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 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 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	Quantity
(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
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14

Medicine	Dose	Duration	Quantity
(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