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: 784-1995-6135536-5
Card Holder's Name: YAKUWA SARU MAGAR Age: 29Y - 0M - 12D Sex: Male
Card Holder's Tel No: Mobile No: 0529099626
Ins Card No: I019-010-119026412-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Nepalese

Clinical Details: Temp38.4 B.P.100 Pulse. 86
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], J20.9 - Acute bronch unspecified, M54.5 - Low back pain, K29.00 - Acute gastritis without bleeding

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-174202-0781, R 40MG , Pharmacy,0188-135906-2441, PULMICORT , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,96365, IV INFUSI THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ S Lab,9, Consultation Gp , General Consultation,96374, THER/PROPH/DIAG INJ IV PL

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 abo 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 co 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)	5	5

Medicine	Dose	Duration	Quantity
(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
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP	SYRUP (200ML, BOTTLE	7	1