

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

D	ate:	23-	Ν	lov	-2	0	24	1
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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: 1019-010-119026412-01 Valid Upto: 7/6/2025

Company FMC Standard Employee

Name: Network No: Nationality:Nepalese



Clinical Details:	Temp <mark>38.4</mark>	B.P. <mark>100</mark>	Pulse. <mark>86</mark>
Signs & Symptoms: risk of	fall		
Date of Onset Illness:		○ Emergency ○ Worl	k related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute up	oper respiratory infection, uns	pecified, J00 - Acute nasopharyngitis	[common cold], J20.9 - Acute broncl
unspecified, M54.5 - Low	back pain, K29.00 - Acute gast	ritis 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 SILab,9, Consultation Gp , General Consultation,96374, THER/PROPH/DIAG INJ IV PL

Doctor's Name: AHSAN HUSSAIN signature with seal:

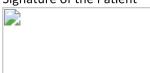
Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER DUBAI - U.A.E.

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 abore 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 cormedical 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