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: 06-Dec-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-8982880-5
Card Holder's Name: Lamarana Bah Age: 27Y - 6M - 1D Sex: Male
Card Holder's Tel No: Mobile No: 0522838139
Ins Card No: I019-010-119614751-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sierra Leonean

Clinical Details: Temp37 B.P.124 Pulse. 78
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follov
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], R10.13 - Epigast M54.5 - Low back pain, K21.9 - Gastro-esophageal reflux disease without esophagitis, E86.0 - Dehydration, M62.830 - Muscle back

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 M SOLUTION FOR INFUSION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-174202-0 40MG , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM Co.Pay,82948, REAGENT STRIP/BLOOD GLUCOSE , Lab,0102-152902-1001, LACTATE HYDRATION IV INFUSION INIT , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: AHSAN HUSSAIN signature with seal:

Dr. Ahsan Hus
General Practitio
DHA No: 8754365
CITICARE MEDICAL CE
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, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 06-Dec-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	5	5
(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	Quant
(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	SUGAR COATED TABLETS (30S, BLISTER PACK)	7	14