



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: 784-1998-2521328-5

Card Holder's Name: NEETA HARIBHAI KHIMSURIYA HARIBHAI ANANDBHAI KHIMSURIYA Age: 26Y - 2M - 18D Sex: Female

Card Holder's Tel No: Mobile No: 0568678104

Ins Card No: I005-010-121540611-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: Nationality: Indian



Clinical Details: Temp 36.5 B.P. 116 Pulse. 74
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J00 - Acute nasopharyngitis [common cold], J20.9 - Acute bronchitis, unspecified, M54.5 - Low back pain, E86.0 - Dehydration, K21.9 - Gastro-esophageal reflux disease without esophagitis

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 0125-1221C
DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 0005-174202-0781, RISEK 40MG , Pharmacy, 96365, IV INFUSION
THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0102-152902-1001, LACTATED
INJECTION USP , Pharmacy, 96360, HYDRATION IV INFUSION INIT , Co.Pay, 0188-135
INHALATION TREATMENT , Co.Pay, 0195-107704-0801, CEFTRIAXONE-TABUK IV , Ph

Dr. Ahsan Hussain
General Practitioner
DHA No: 8754365
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Doctor's Name: AHSAN HUSSAIN

signature with seal:

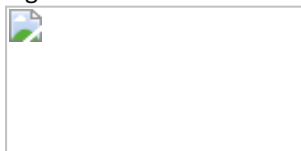
Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the 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 06-Dec-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
(AZITHROMYCIN : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER PACK	5	5
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14

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