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

WE TAKE CARE OF YOU

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: Temp36.5 B.P.116 Pulse. 74
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], J20.9 - Acute bro 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 Hus
General Practitio
DHA No: 8754365
CITICARE MEDICAL CE
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, 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	Quanti
(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