

**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 formDate: **06-Dec-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1995-2027746-0**Card Holder's Name: **MOHIT KUMAR NARESH CHANDRA** Age: **29Y - 5M - 11D** Sex: **Male**Card Holder's Tel No: Mobile No: **0564670216**Ins Card No: **I005-010-117742793-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**

Clinical Details: Temp **36** B.P. **107** Pulse. **86**
 Signs & Symptoms: **risk of fall**
 Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow
 Diagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, K29.00 - Acute gastritis without bleeding**

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SC INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRV INHALATION TREATMENT , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: **Humaira**

signature with seal:

Dr. Humaira M
 General Practitioner
 DHA No: 541555
CITICARE MEDICAL I
 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, 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	7	7
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1

Medicine	Dose	Duration	Quantity
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES	DELAYED RELEASE CAPSULES (30S, CONTAINER)	7	14