

ANNEXURE V 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: 08-Dec-2024	Date:	08-	Dec-	2024
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Name:

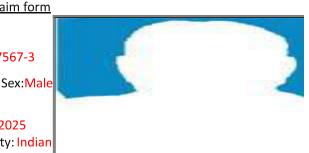
Emirates: 784-2002-1207567-3 Clinic Name: CITICARE MEDICAL CENTER LLC

Card Holder's CHRISTEN DANELO AROKIADHAS

AROKIADHAS

Card Holder's Tel No: Mobile No: 0507386551

1019-010-118408971-01 Ins Card No: Valid Upto: 7/6/2025 Company Name: FMC Standard Network Employee No: Nationality: Indian



Clinical Details: T	emp <mark>36</mark>	B.P. <mark>129</mark>	Pulse. 101			
Signs & Symptoms: risk of fall						
Date of Onset Illness :		○ Emergency ○ W	ork related O New visit O Follow up			
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, <code>CEFTRIAXONE-TABUK</code> IV , <code>Pharmacy</code>,96365, <code>IV</code> <code>INFUSION</code> <code>THERAPY</code>/<code>PROPHYLAXIS</code> /<code>DX</code> 1ST <code>TO</code> 1 HR , <code>Co.Pay</code>,000149902-1021, CLOFEN -(DICLOFENAC SODIUM: 75 MG/3ML) SOLUTION FOR INJECTION, Pharmacy,96372, THER/PROPH/DIAG IN Co.Pay,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSIC

NEBULIZATION, Pharmacy, 9, Consultation Gp, General Consultation

Doctor's Name: Humaira signature with seal:

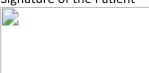
Dr. Humaira Mumta General Practitioner DHA No: 54155530-00 CITICARE MEDICAL CENTE

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 above 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 con medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 08-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)	10	10

Medicine	Dose	Duration	Quantity
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(AZITHROMYCIN: 500 MG FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER	7	7
(MONTELUKAST (AS SODIUM : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK	30	30
(PREDNISOLONE : 20 MG TABLETS	TABLETS (1000S, BLISTER PACK	7	7
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1