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: 10-Dec-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-6743607-4
Card Holder's Name: LARISHA LAMARE DHONSINGH MARING Age: 25Y - 0M - 24D Sex: Female
Card Holder's Tel No: Mobile No: 0505690673
Ins Card No: I019-010-119760966-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 37 B.P. 130 Pulse. 98
Signs & Symptoms: risk for fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up visit
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R07.9 - Chest pain, unspecified, R50.9 - Fever, unspecified, J20.9 - Acute bronchitis, unspecified, J30.9 - Allergic rhinitis, unspecified, M54.5 - Low back pain, M62.81 - Muscle weakness (generalized), R53.1 - Weakness, E86.0 - Dehydration

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,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,0005-174202-0781, RISEK 40MG , Pharmacy,0188-135906-2441, PULMICORT , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0125-122107-1022,
DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,96365, IV INFUSION THERAPY THER/PROPH/DIAG INJ SC/IM , Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.P 9, Consultation Gp , General Consultation

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
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 above-mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 10-Dec-2024

12/10/2024 12:32:07 AM

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14	0.0000
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14	0.0000
(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	SUGAR COATED TABLETS (30S, BLISTER PACK)	7	14	0.0000