

**ANNEXURE V****F M C NETWORK UAE**

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**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 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



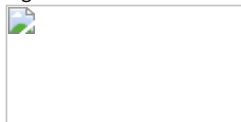
|                                                                                                                                                                                                                                                                                                                     |                                                                                                                                          |          |           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------|
| Clinical Details:                                                                                                                                                                                                                                                                                                   | Temp 37                                                                                                                                  | B.P. 130 | Pulse. 98 |
| Signs & Symptoms:                                                                                                                                                                                                                                                                                                   | risk for fall                                                                                                                            |          |           |
| Date of Onset Illness :                                                                                                                                                                                                                                                                                             | <input type="radio"/> Emergency <input type="radio"/> Work related <input type="radio"/> New visit <input type="radio"/> 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: Consultation Gp , General Consultation |                                                                                                                                                                                               |
| 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 |