**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

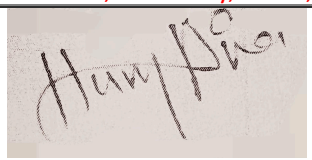
Date: 13-Dec-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-2652634-7
Card Holder's Name: SHAN MOHAMMAD SURAJ KHAN Age: 26Y - 6M - 26D Sex: Male
Card Holder's Tel No: Mobile No: 0565578605
Ins Card No: I005-010-121540511-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp37.5 B.P.117 Pulse. 91
Signs & Symptoms: THANK YOU
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J02.9 - Acute pharyngitis, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, Cough, K29.00 - Acute gastritis without bleeding, R09.81 - Nasal congestion

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,2190-106618-1001, PARAFUSIV I
10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1
HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0188-135906-2441, PULMICORT , Pharmacy,94640, AIRWAY INHALATIO
TREATMENT , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: Humaira 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 abo 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 co medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 13-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 |

| Medicine | Dose | Duration | Quantity |
|---|---|---|---|
| (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS | TABLETS (14S, BLISTER PACK) | 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 |
| (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES | DELAYED RELEASE CAPSULES (30S, CONTAINER) | 7 | 14 |