



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

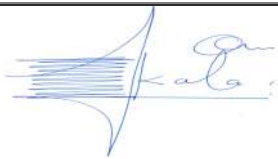
Date: **14-Dec-2024**

Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1997-4861315-7**
 Card Holder's Name: **PETER GITAH MBURU** Age: **27Y - 2M - 24D** Sex: **Male**
 Card Holder's Tel No: Mobile No: **0503382031**
 Ins Card No: **I005-010-119384583-01** Valid Upto: **30/9/2025**
 Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Kenyan**



Clinical Details: Temp **38** B.P. **133** Pulse. **98**
 Signs & Symptoms: **risk of fall**
 Date of Onset Illness : _____
 Diagnosis: **J03.90 - Acute tonsillitis, unspecified, J01.00 - Acute maxillary sinusitis, unspecified, R50.9 - Fever, unspecified**

Management plan (Services inside the clinic including injections and investigations)
96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMETHASONE SOC PHOSPHATE , Pharmacy,9, Consultation Gp , General Consultation

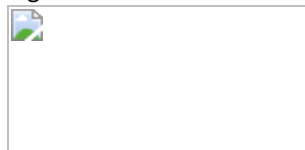
Doctor's Name: **Enomen Goodluck** signature with seal: 


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 a person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **14-Dec-2024**



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK	10	20
(IBUPROFEN : 400 MG TABLETS	TABLETS (24S, BLISTER PACK	4	12

Medicine	Dose	Duration	Quantity
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	5