

**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 formDate: **16-Dec-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1989-1679085-4**Card Holder's Name: **DIMPLES PEREZ VERGEL DE DIOS** Age: **35Y - 9M - 9D** Sex: **Female**Card Holder's Tel No: Mobile No: **0582974281**Ins Card No: **I019-010-118822446-01** Valid Upto: **7/6/2025**Company **FMC Standard** Employee _____ Nationality: **Philippine**Name: **Network** No: _____Clinical Details: Temp **36** B.P. **136** Pulse. **86**Signs & Symptoms: **RISK OF FALL**Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **N23 - Unspecified renal colic, R10.31 - Right lower quadrant pain, R51.9 - Headache, unspecified**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,0078-149902-10
(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST
Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,9, Consultation Gp , General Consult

Dr. Ahsan Hussain
 General Practitioner
 DHA No: 87543658-001
CITICARE MEDICAL CENTER
 DUBAI - U.A.E.

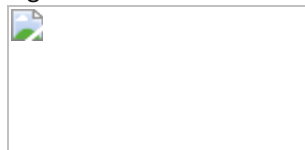
Doctor's Name: **AHSAN HUSSAIN**

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 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 **16-Dec-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(IBUPROFEN : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	7	14

