



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: 20-Dec-2024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1989-7985386-2

Card Holder's Name: JOHN DANIEL WACHIURI NGUNJIRI Age: 35Y - 2M - 15D Sex: Male

Card Holder's Tel No: Mobile No: 0521403376

Ins Card No: I019-010-118887433-01 Valid Upto: 7/6/2025

Company Name: FMC Standard Network Employee No: Nationality: Kenyan



Clinical Details:	Temp 38	B.P. 166	Pulse. 103
Signs & Symptoms: risk of fall			
Date of Onset Illness :		☐ Emergency ☐ Work related ☐ New visit ☐ Follow up	
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J20.9 - Acute bronchitis, unspecified, M54.5 - Low back pain, K21 Gastro-esophageal reflux disease without esophagitis			

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/IV SOLUTION FOR INFUSION , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 9, Consultation Gp , General Cons

Doctor's Name: AHSAN HUSSAIN

signature with seal:

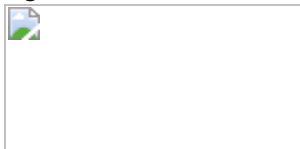


Diagnostic Procedures referred outside:

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 20-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	14
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP	SYRUP (200ML, BOTTLE	7	1