

**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: **22-Dec-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-2002-2047019-7**Card Holder's Name: **DICKY WAHYU AL KAFFY** Age: **22Y - 6M - 18D** Sex: **Male**Card Holder's Tel No: Mobile No: **0547954546**Ins Card No: **I019-010-117336271-01** Valid Upto: **7/6/2025**Company **FMC Standard** Employee
 Name: **Network** No: _____ Nationality: **Indonesian**Clinical Details: Temp **36.8**B.P. **120**Pulse. **74**Signs & Symptoms: **RISK FOR FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
Diagnosis: **R50.9 - Fever, unspecified, N39.0 - Urinary tract infection, site not specified, R05 - Cough, J30.9 - Allergic rhinitis,**

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

85027, COMPLETE CBC AUTOMATED , Lab,81005, URINALYSIS , Lab,9, Consultation Gp , General ConsultationDoctor's Name: **SANDIA**

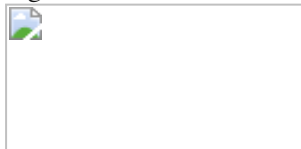
signature with seal:

Dr. Sandia Bh
 General Practitioner
 DHA No: 659002
PESHAWAR MEDICAL
 DUBAI - U.A.E.

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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **22-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)	5	1
(CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER)	5	10
(HEDERA HELIX (IVY) : 7MG/ML) SYRUP	SYRUP (200ML, GLASS BOTTLE)	10	10

Medicine	Dose	Duration	Quantity
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (48S, BOX)	5	15