



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: 23-Dec-2024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-6128464-6
Card Holder's Name: AMIR ASHRAF MUHAMMAD ASHRAF Age: 26Y - 4M - 22D Sex: Male
Card Holder's Tel No: Mobile No: 052619684
Ins Card No: I019-010-119871074-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: Nationality: Pakistani



Clinical Details: Temp 37.5 B.P. 150 Pulse. 94
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, J20.9 - Bacterial rhinitis, unspecified, J21.9 - Viral rhinitis, unspecified, J22.9 - Allergic rhinitis, unspecified, J23.9 - Bacterial rhinitis, unspecified, J24.9 - Viral rhinitis, unspecified, J25.9 - Bacterial rhinitis, unspecified, J26.9 - Viral rhinitis, unspecified, J27.9 - Bacterial rhinitis, unspecified, J28.9 - Viral rhinitis, unspecified, J29.00 - Acute gastritis without bleeding

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SC INJECTION , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Co.Pay, 9, Consultation Gp , General Consultation

Dr. Humaira M
General Practitioner
DHA No: 541555
CITICARE MEDICAL CENTER
DUBAI - U.A.E

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 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 23-Dec-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	6	12
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	7
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5

Medicine	Dose	Duration	Quantity
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	CAPSULES (HARD GELATIN (14S, BLISTER	7	14