

**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: **26-Dec-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1984-4150396-2**Card Holder's Name: **FAISAL MEHMOOD MOHAZZAM ALI** Age: **40Y - 11M - 28D** Sex: **Male**Card Holder's Tel No: Mobile No: **559184410**Ins Card No: **I019-010-112614603-01** Valid Upto: **7/6/2025**Company: **FMC Standard** Employee: _____ Nationality: **Pakistani**
 Name: **Network** No: _____Clinical Details: Temp **36** B.P. **115** Pulse. **70**Signs & Symptoms: **RISK OF FALL**Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, R07.89 - Other chest pain**Management plan (Services inside the clinic including injections and investigations)

94640, AIRWAY INHALATION TREATMENT , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION Pharmacy,0006-402803-2071, VENTOLIN NEBULES , Pharmacy,0188-135906-2441, PULMICORT , Pharmacy,85025, COMPLETE CBC DIFF WBC , Lab,9, Consultation Gp , General Consultation

Dr. Enomen Goodluck I
 General Practitioner
 DHA No: 28040827-00
CITICARE MEDICAL CENTRE
 DUBAI - U.A.E.

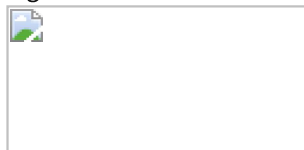
Doctor's Name: **Enomen Goodluck**

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 **26-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
(PREDNISOLONE : 5 MG TABLETS	TABLETS (20S, BLISTER PACK	7	14

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	7	1