

**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: 27-Dec-2024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-5878794-2

Card Holder's Name: MARIAM ANUAR Age: 28Y - 0M - 21D Sex: Female

Card Holder's Tel No: Mobile No: 0551944687

Ins Card No: I005-010-121540491-01 Valid Upto: 30/9/2025

Company: FMC Standard Employee: _____ Nationality: Ugandan
 Name: Network No: _____

Clinical Details: Temp 38.3 B.P. 112 Pulse. 84

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, K29.00 - Acute gastritis without bleeding

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

0005-149902-1021, CLOFEN , Pharmacy, 0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy, 2190-106618-1001, PARAFUSIV I.
 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 15
 HR , Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION
 NEBULIZATION , Pharmacy, 94640, AIRWAY INHALATION TREATMENT , Co.Pay, 9, Co

Doctor's Name: SANDIA

signature with seal:

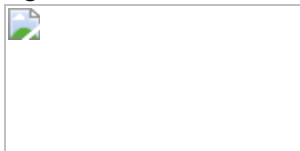
Dr. Sandia Bhojwa
 General Practitioner
 DHA No: 65900212-00
 PESHAWAR MEDICAL CENT
 DUBAI - U.A.E.

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 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 27-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

Medicine	Dose	Duration	Quantity
(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
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES	DELAYED RELEASE CAPSULES (30S, CONTAINER)	7	14