

**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: **28-Dec-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1998-2237484-1**Card Holder's Name: **HTET LYNN** Age: **26Y - 3M - 12D** Sex: **Male**Card Holder's Tel No: Mobile No: **0558553186**Ins Card No: **I005-010-120076121-01** Valid Upto: **30/9/2025**Company **FMC Standard** Employee _____ Nationality: **Myanmarese**
 Name: **Network** No: _____Clinical Details: Temp **36.8** B.P. **128** Pulse. **76**Signs & Symptoms: **RISK OF FALL**Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **A09 - Infectious gastroenteritis and colitis, unspecified, R19.7 - Diarrhea, unspecified, R53.1 - Weakness, E86.0 - Dehydr**Management plan (Services inside the clinic including injections and investigations)

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0131-116601-1001, (METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION
Pharmacy,0005-174202-0781, RISEK 40MG , Pharmacy,0005-136504-1021, SCOPINAL , Pharmacy,96360, HYDRATION IV INFUSION
Co.Pay,0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,9, Consultation Gp , General Consultation,96365, IV INFUSION
THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SI
Co.Pay

Doctor's Name: **Enomen Goodluck**

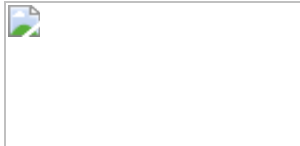
signature with seal:

Dr. Enomen Goodluck I
 General Practitioner
 DHA No: 28040827-00
CITICARE MEDICAL CENTRE
 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 and medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **28-Dec-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (6S, BLISTER PACK)	1	2

Medicine	Dose	Duration	Quantity
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14
(PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS	ENTERIC COATED TABLETS (15S, BLISTER)	10	20
(SPORE OF BACILLUS CLAUSI : 2 BILLION/5ML) SUSPENSION	SUSPENSION (10 X 5ML, BOTTLE)	7	14