

**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: **30-Dec-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-2003-9686024-7**Card Holder's Name: **AIYSHA ABDUL GAFFAR** Age: **21Y - 5M - 5D** Sex: **Female**Card Holder's Tel No: Mobile No: **0559951783**Ins Card No: **I005-010-121540490-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**

Clinical Details: Temp **36.9** B.P. **126** Pulse. **74**
 Signs & Symptoms: **RISK FOR FALL**
 Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow
 Diagnosis: **N10 - Acute pyelonephritis, J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, M79.: unspecified site, K29.70 - Gastritis, unspecified, without bleeding**

Management plan (Services inside the clinic including injections and investigations)**81005, URINALYSIS , Lab,85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,9, Consultation Gp , General Consultation**Doctor's Name: **Enomen Goodluck**

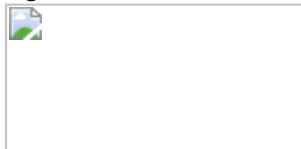
signature with seal:

Dr. Enomen Goodluck
 General Practitioner
 DHA No: 280408
CITICARE MEDICAL CENTER
 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 **30-Dec-2024**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14
(CIPROFLOXACIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	10
(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	4	8

Medicine	Dose	Duration	Quantity
(ESOMEPRAZOLE : 40 MG FILM COATED TABLETS	FILM COATED TABLETS (14S, BLISTER PACK	14	14
(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (100ML, GLASS BOTTLE)	7	1
(PREDNISOLONE : 5 MG TABLETS	TABLETS (20S, BLISTER PACK	7	14