

**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: 01-Jan-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-2471130-4
 Card Holder's Name: DAVID OBLIGAR GALANG Age: 25Y - 1M - 7D Sex: Male
 Card Holder's Tel No: Mobile No: 0529374251
 Ins Card No: I019-010-117477483-01 Valid Upto: 7/6/2025
 Company FMC Standard Employee
 Name: Network No: _____ Nationality: Philippine



Clinical Details: Temp 38.6 B.P. 113 Pulse: 78
 Signs & Symptoms: RISK OF FALL
 Date of Onset Illness :
☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
 Diagnosis: J02.9 - Acute pharyngitis, unspecified, J20.9 - Acute bronchitis, unspecified, R50.9 - Fever, unspecified, M79.10 - Myalgia unspecified site

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

96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,00149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,96372, THER/PROPH/ISC/IM , Co.Pay,96375, TX/PRO/DX INJ NEW DRUG ADDON , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: Enomen Goodluck

signature with seal:

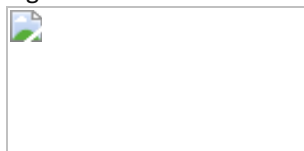
Dr. Enomen Goodluck I
 General Practitioner
 DHA No: 28040827-00
 CITICARE MEDICAL CENTRE
 DUBAI - U.A.E.

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, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 01-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	6	6

Medicine	Dose	Duration	Quantity
(LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5
(IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER	5	15
(PHENOL : 1.5% W/W) SPRAY	SPRAY (177ML, SPRAY BOTTLE)	7	1
(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, GLASS BOTTLE)	7	1