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

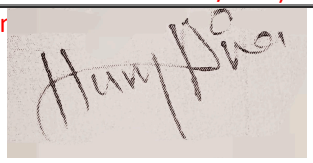
Date: 02-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1991-6693702-1
Card Holder's Name: RAJAB MABERI Age: 33Y - 2M - 16D Sex: Male
Card Holder's Tel No: Mobile No: 0581933015
Ins Card No: I005-010-121632954-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Ugandan

Clinical Details: Temp36.6 B.P.130 Pulse. 84
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified, R19.7 - Diarrhea, unspecified, R50.9 - Fever, unspecified, R11.0

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

0148-116601-1001, (METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION , Pharmacy,0005-136504-1021, SCOPINAL-(HY
20 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372,
THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECT
Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9, Consultation Gp , Ger

Doctor's Name: Humaira 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 abo
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 co
medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 02-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER)	7	7

Medicine	Dose	Duration	Quantity
(METRONIDAZOLE : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK	7	14
(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (28.5G X 10, SACHET)	5	5
(DOMPERIDONE : 1 MG/ML) SUSPENSION	SUSPENSION (200ML, GLASS BOTTLE)	1	1
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	6	12