

**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 - 8D Sex: Male

Card Holder's Tel No:

Mobile No: 0581933015

Ins Card No: I005-010-121632954-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Ugandan



Clinical Details:

Temp 36.6

B.P. 130

Pulse. 84

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified, R19.7 - Diarrhea, unspecified, R50.9 - Fever, unspecified, R1

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 20 MG/ML) SOLUTION FOR INJECTION , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 9637 THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR IN. Pharmacy, 96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay, 9, Consultation Gp , Ger

Doctor's Name: Humaira

signature with seal:

Dr. Humaira M
 General Practitioner
 DHA No: 541555
 CITICARE MEDICAL I
 DUBAI - U.A

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 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
(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

Medicine	Dose	Duration	Quantity
(DOMPERIDONE : 1 MG/ML) SUSPENSION	SUSPENSION (200ML, GLASS BOTTLE)	1	1
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	6	12