

**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: 05-Jan-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-9156339-1

Card Holder's Name: Koustav Roy Age: 28Y - 8M - 11D Sex: Male

Card Holder's Tel No: Mobile No: 0564681938

Ins Card No: I019-010-121885619-01 Valid Upto: 7/6/2025

Company Name: FMC Standard Network Employee No: _____ Nationality: Indian



Clinical Details: Temp 38 B.P. 132 Pulse. 74

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R50.9 - Fever, unspecified, J30.9 - Allergic rhinitis, unspecified, K29.00 - Acute gastritis without bleeding

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLU
 INJECTION , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION ,
 Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 01:
 135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZ
 TREATMENT , Co.Pay, 9, Consultation Gp , General Consultation

Doctor's Name: Humaira

signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTE
 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 05-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5

Medicine	Dose	Duration	Quantity
(AZITHROMYCIN : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER	7	7
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	CAPSULES (HARD GELATIN (14S, BLISTER	7	14
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	6	12
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1