

**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: **13-Jan-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1993-1682852-6**Card Holder's Name: **KAOUTAR BENCHELHA**Age: **31Y - 6M - 0D** Sex: **Female**

Card Holder's Tel No:

Mobile No:

0563229007Ins Card No: **I005-010-116461315-01**Valid Upto: **30/9/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Moroccan**

Clinical Details:

Temp **36.7**B.P. **140**Pulse. **74**Signs & Symptoms: **RISK FOR FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: **J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, R21 - Rash and other nonspecific skin eruption**

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

0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRWAY INT TREATMENT , Co.Pay,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SOD MG/3ML) 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,9, Consultation Gp , General Consultation

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 **13-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)	10	10
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	7
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	6	12

Medicine	Dose	Duration	Quantity
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	CAPSULES (HARD GELATIN (14S, BLISTER	7	14
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10