

**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: **22-Jan-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1995-7150306-1**Card Holder's Name: **TANVEER AHMAD**Age: **27Y - 0M - 21D** Sex: **Male**

Card Holder's Tel No:

Mobile No: **566919855**Ins Card No: **I020-010-117415414-03**Valid Upto: **27/4/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Pakistani**

Clinical Details:

Temp **36**B.P. **116**Pulse. **68**Signs & Symptoms: **risk of fall**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
Diagnosis: **J45.991 - Cough variant asthma, J20.9 - Acute bronchitis, unspecified, J43.9 - Emphysema, unspecified**Management plan (Services inside the clinic including injections and investigations)

**85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,9, Consultation Gp , General Consultation,94640, AIRWAY INHALATION TREATME
 Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,96372, THER/PRC
 INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay**

Doctor's Name: **SANDIA**

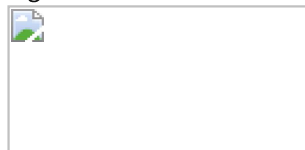
signature with seal:



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 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 **22-Jan-2025**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CEFPODOXIME (AS PROXETIL : 200 MG TABLETS	TABLETS (15S, BLISTER PACK	5	5
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	7	7

Medicine	Dose	Duration	Quantity
(TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP	SYRUP (200ML, BOTTLE)	7	21
(BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP	SYRUP (100ML, BOTTLE)	5	5
(MONTELUKAST (AS SODIUM : 10 MG TABLETS	TABLETS (30S, BLISTER	15	15