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: 22-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-7150306-1
Card Holder's Name: TANVEER AHMAD Age: 27Y - 0M - 28D Sex: Male
Card Holder's Tel No: Mobile No: 566919855
Ins Card No: I020-010-117415414-03 Valid Upto: 27/4/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details: Temp36 B.P.116 Pulse. 68
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follo
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,94640, AIRWAY INHALATION TREATMENT , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,96372, THER/PR INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,9, Consultation Gp , Ger

Consultation

Doctor's Name: SANDIA signature with seal:

Dr. Sandia Bh
General Practit
DHA No: 659002
PESHAWAR MEDICAL
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 a 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 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	Quant
(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
(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

Medicine	Dose	Duration	Quant
(MONTELUKAST (AS SODIUM : 10 MG TABLETS	TABLETS (30S, BLISTER	15	15