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: 30-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-4725140-5
Card Holder's Name: VIVIAN CHELIMO Age: 27Y - 5M - 8D Sex: Female
Card Holder's Tel No: Mobile No: 0527195419
Ins Card No: I019-010-120140263-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No:_____ Nationality: Kenyan

Clinical Details: Temp36.6 B.P.130 Pulse. 78
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: R21 - Rash and other nonspecific skin eruption, R50.9 - Fever, unspecified

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,0148-116603-1111, (METRONIDAZOLE : 200 MG/5ML) SUSPENSION , Pharmacy,0135-149902-0511, (DICLOFENAC SODIUM : 75 MG/3ML) INJECTION , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtia
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CEN
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 abo 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 co medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 30-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14

Medicine	Dose	Duration	Quantity
(HYOSCINE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (200S, BLISTER PACK	4	8
(METRONIDAZOLE : 1.3%) VAGINAL GEL	VAGINAL GEL (5G, TUBE)	5	10
(CLAVULANIC ACID : 125 MG (AMOXICILLIN : 875 MG TABLETS	TABLETS (14S, STRIP	3	3