

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

Da	ate:	: 0	/-H	-ei	3-2	U.	25

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1992-7086064-8 Card Holder's Name: MOHAMMED KIWEESI Age: 32Y - 6M - 28D Sex: Male

Card Holder's Tel No: Mobile No: 0506582466 Ins Card No: 1005-010-118263970-01 30/9/2025 Valid Upto:

Company **FMC Standard** Employee

_Nationality:Ugandan Name: Network No:

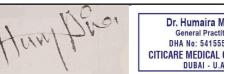


Clinical Details:	Temp <mark>36</mark>	B.P.120	Pulse. 86
Signs & Symptoms: risk o	f fall		
Date of Onset Illness :		○ Emergency ○ Work	related O New visit O Follo
Diagnosis: J06.9 - Acute u R50.9 - Fever, unspecified	• • • • • • • • • • • • • • • • • • • •	nspecified, J00 - Acute nasopharyngitis [d	common cold], R09.81 - Nasal

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 INI TREATMENT, Co.Pay,9, Consultation Gp, General Consultation

signature with seal:



Diagnostic Procedures referred outside:

Doctor's Name: Humaira

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, medica medical services and copies of all medical and Clinic records.

Signature of the Patient



Date 07-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	6	12