



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: 19-Feb-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1999-2494008-5

Card Holder's Name: ni luh era novita

Age: 25Y - 5M - 8D Sex: Female

Card Holder's Tel No:

Mobile No:

0562159853

Ins Card No: I005-010-120488194-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Indonesian



Clinical Details:

Temp 36.4

B.P. 116

Pulse: 86

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J01.41 - Acute recurrent pansinusitis, J45.991 - Cough variant asthma, R51.9 - Headache, unspecified, R50.9 - Fever, unspecified, E86.0 - Dehydration

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

85027, COMPLETE CBC AUTOMATED , Lab,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT- (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10 INFUSION , Pharmacy,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,012 PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , Ge
Doctor's Name: DR Amaizah signature with seal:

Amaizah

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

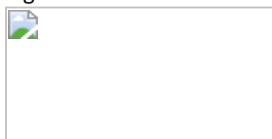
TO

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 any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 19-Feb-2025



Pharmaceuticals (to be filled by treating doctor only)