ANNEXURE V

F M C NETW

P. O. BOX: 50430, DUBAI, **Tel – 04**
Email – approval@fmchealthcare.ae **F**

Medical Expenses Claim form

Date: 25-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-8944541-3
Card Holder's Name: MOHAMED SAFNI NIZAM Age: 24Y - 3M - 24D Sex: Male
Card Holder's Tel No: Mobile No: 0565727014
Ins Card No: I005-010-120076119-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp37.6 B.P.96
Signs & Symptoms:
Date of Onset Illness :
○ Emergency
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R05 - Cou

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION
CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,
IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0125-122107-1022, DE
(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96360, HYD
PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharm
(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION , Pharmacy,0102-100104-10
CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION , Pharmacy,9.01, Fre
Consultation,99640, AIRWAY INHALATION TREATMENT , Co.Pay

Doctor's Name: Humaira signature with seal:

Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical servi
mentioned examination/Investigation/therapy is given to me by the doctor. I hereby a
person who has provided medical services to me to furnish any and all information wit
medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 25-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)