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: 27-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1984-4150396-2
Card Holder's Name: FAISAL MEHMOOD MOHAZZAM ALI Age: 41Y - 1M - 26D Sex:Male
Card Holder's Tel No: Mobile No: 559184410
Ins Card No: I019-010-112614603-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details: Temp36 B.P.132 Pulse. 70
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, J45.991 - Cough variant asthma, J30.9 - Allergic rhinitis, unspecified

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZ[illegible] M , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,012C[illegible] (DEXTROMETHORPHAN : 5 MG/5ML) SYRUP , Pharmacy,9, Consultation Gp , Gene[illegible] ADDON , Co.Pay

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
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 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 27-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	3	3	0.9000
(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	5	10	0.0000
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	3	6	0.0000