



ANNEXURE V

F M C NETV

P. O. BOX: 50430, DUBAI, Tel – (

Email – approval@fmchealthcare.ae

Medical Expenses Claim for

Date: **01-Mar-2025**

Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1998-8482131-7**

Card Holder's Name: **KHARAK SINGH KISHAN SINGH** Age: **26Y - 7M - 14D** Sex: **Ma**

Card Holder's Tel No: Mobile No: **0569469783**

Ins Card No: **I005-010-119076401-01** Valid Upto: **30/9/2025**

Company Name: **FMC Standard Network** Employee No: _____ Nationality: **India**

Clinical Details: Temp **36** B.P. **102**
Signs & Symptoms: **RISK FOR FALL**
Date of Onset Illness : ☐ Emergenc
Diagnosis: **J02.9 - Acute pharyngitis, unspecified, J03.90 - Acute tonsillitis, unspecified, E86.0 - Dehydration**

Management plan (Services inside the clinic including injections and investigation
85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0195-107704-0801, CEFTRIAXONE-TREATMENT , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HI Co.Pay,9, Consultation Gp , General Consultation,0102-152902-1001, LACTATED RI INFUSION INIT , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/V

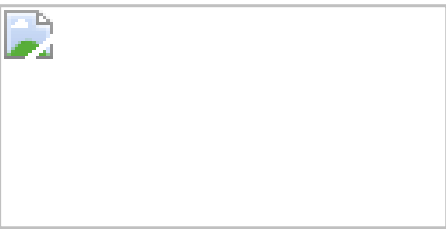
Doctor's Name: **DR Amaizah**

signature with seal:

Diagnostic Procedures referred outside:

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

Signature of the Patient



Date 01-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (BOTTLE)
(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (STRIP
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (BLISTER PACK
(IMIQUMOD : 5%) CREAM	CREAM (250