

**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 formDate: **01-Mar-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1999-5399530-7**Card Holder's Name: **EMARIE COMIA ALVASAN**Age: **25Y - 9M - 20D** Sex: **Female**

Card Holder's Tel No:

Mobile No:

0565416389Ins Card No: **I005-010-121629989-01**Valid Upto: **30/9/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Philippine**

Clinical Details:

Temp **37.2**B.P. **103**Pulse. **79**

Signs & Symptoms:

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
Diagnosis: **J02.9 - Acute pharyngitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified**Management plan (Services inside the clinic including injections and investigations)

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE MG/ML) SOLUTION FOR INJECTION , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLU' INFUSION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9, Consultation General Consultation

Doctor's Name: **Humaira**

signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTE
 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 a person who has provided medical services to me to furnish any and all information with regard to any medical history, medical consultation, 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	Duration	Quantity
(AZITHROMYCIN : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER	5	10

Medicine	Dose	Duration	Quantity
(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	TABLETS (24S, BLISTER PACK)	5	10
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	5	10