

**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: **10-Mar-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1997-2652787-4**Card Holder's Name: **PRIYA SAHU ARUN KUMAR SAHU** Age: **27Y - 5M - 25D** Sex: **Female**Card Holder's Tel No: Mobile No: **+919630911307**Ins Card No: **I005-010-118997977-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**

Clinical Details: Temp **37** B.P. **113** Pulse. **75**
Signs & Symptoms:
Date of Onset Illness : _____
☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
Diagnosis: **J02.9 - Acute pharyngitis, unspecified, J30.9 - Allergic rhinitis, unspecified, J45.991 - Cough variant asthma, R50.9 - Fever, unspecified**

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation

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

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 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 **10-Mar-2025****Pharmaceuticals (to be filled by treating doctor only)**

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG (AMOXICILLIN : 875 MG TABLETS	TABLETS (14S, STRIP	5	5	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (200S, BLISTER PACK)	7	7	0.0000
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	5	5	0.9000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	3	6	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG FILM COATED TABLETS	FILM COATED TABLETS (28S, HDPE BOTTLE	5	5	1.9600