

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: 1	13-N	1ar-2	025

Card Holder's Tel No:

Emirates: 784-1981-2591068-1 Clinic Name: CITICARE MEDICAL CENTER LLC

Card Holder's MOHAMMED ANWAR MOHAMMED

Sex:Male

Name: ISMAIL TAMBOLI

0553251280 Mobile No:

Ins Card No: 1005-010-120488192-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: ______ Nationality: Indian



Clinical Details:	Temp <mark>37.1</mark>	B.P. 110	Pulse. 92
Signs & Symptoms: risk of	fall		
Date of Onset Illness:		○ Emergency ○ W	ork related ○ New visit ○ Follow
Diagnosis: J06.9 - Acute up	oper respiratory infection, uns	pecified, R05 - Cough, R50.9 - Feve	r, unspecified, K29.00 - Acute gastri
bleeding			

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 M(-SOLUTION FOR INFUSION , Pharmacy,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Pharmacy,0125-122107 DEXAMETHASONE SODIUM PHOSPHATE, Pharmacy, 85027, COMPLETE CBC AUTOMATED, Lab, 94640, AIRWAY INHALATION TR

Co.Pay,0188-135906-2441, PULMICORT, Pharmacy,0005-149902-1021, CLOFEN, F Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR, Co.Pay,9, Cc

Dr. Amaizah Isl General Practitio DHA: 98486553-0 CITICARE MEDICAL DUBAI - U.A.E

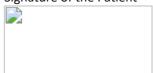
Doctor's Name: DR Amaizah signature with seal:

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 a mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy c person who has provided medical services to me to furnish any and all information with regard to any medical history, medical medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 13-Mar-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quanti		
(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	7	14		
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	5	5		
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG FILM COATED TABLETS	FILM COATED TABLETS (28S, HDPE BOTTLE	7	7		

Medicine	Dose	Duration	Quanti
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (48S, BLISTER PACK)	3	6
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5
(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	SYRUP (5ML X 20, SACHET)	7	1