

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: 14-Mar-2025

Clinic Name: CITICARE MEDICAL CENTER LLC
Card Holder's Name: KHIN MAUNG WIN

Card Holder's Tel No: Mobile No: Ins Card No: I019-010-121537023-01
Company FMC Standard Employee

Name: Network

twork No:

Emirates: 784-2000-1829920-4 Age: 24Y - 7M - 5D Sex: Male

> 971503979394 Valid Upto: 7/6/2025

> > _Nationality: Myanmarese



Clinical Details:	Temp36.7	B.P.120	Pulse. 76
Signs & Symptoms: RISK F	OR FALL		
Date of Onset Illness :		○ Emergency ○ Wor	rk related O New visit O Follo
Diagnosis: J06.9 - Acute up Wheezing	oper respiratory infection, uns	specified, R50.9 - Fever, unspecified, J	30.9 - Allergic rhinitis, unspecific

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pha THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,9, Consultation G

Consultation

Doctor's Name: AISHA

signature with seal:

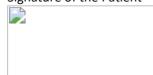
Dr. Aisha U Physician- General P DHA- 40131439 CITICARE MEDICA DUBAI - U.A

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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy 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 14-Mar-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	15
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	3	6
(AMOXICILLIN : 250 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10

Medicine	Dose	Duration	Quan
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10