



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

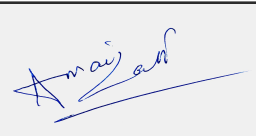
Medical Expenses Claim form

Date: 04-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-6369543-4
Card Holder's Name: CEL JOHN NICOPOR RIOBUYA Age: 26Y - 1M - 22D Sex: Male
Card Holder's Tel No: Mobile No: 5565484824
Ins Card No: I005-010-121925255-01 Valid Upto: 30/9/2025
Company FMC Standard Employee No: Nationality: Philippine
Name: Network



Clinical Details: Temp 37.3 B.P. 150 Pulse. 84
Signs & Symptoms: RISK of FALL
Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
Diagnosis: R21 - Rash and other nonspecific skin eruption, R50.9 - Fever, unspecified, L04.0 - Acute lymphadenitis of face, head and neck

Management plan (Services inside the clinic including injections and investigations)
0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 85027, COMPLETE CBC AUTOMATED , Lab, 9, Consultation Gp , General Co.Pay
Doctor's Name: DR Amaizah signature with seal: 

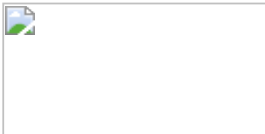
Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

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 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 04-Apr-2025



Pharmaceuticals (to be filled by treating doctor only)