

**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

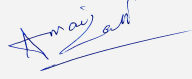
Medical Expenses Claim form

Date: 05-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2001-5873029-9
Card Holder's Name: REJO REJI JOHN REJI JOHN Age: 24Y - 2M - 13D Sex: Male
Card Holder's Tel No: Mobile No: 971566442706
Ins Card No: 1005-010-120341560-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian



Clinical Details:	Temp 36.7	B.P. 120	Pulse. 78
Signs & Symptoms:	RISK FOR FALL		
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R50.9 - Fever, unspecified, R52 - Pain, unspecified, K29.00 - Acute gastritis without bleeding, E86.0 - Dehydration			

Management plan (Services inside the clinic including injections and investigations)	
2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,0384-207801-1002, LACTATED RINGER'S & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION (500ML, BOTTLE) , Pharmacy,96360, HYD CBC AUTOMATED , Lab,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHA 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 05-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	1	10	0.0000
(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (30S, SACHET)	2	2	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS	FILM COATED TABLETS (28S, HDPE BOTTLE)	5	5	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (24S, BLISTER PACK)	3	6	0.0000