

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: 08-Apr-2025

GI: : 1 D : :I

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1983-7195085-2 Card Holder's Name: NAWROZ ALI MOHAMMAD AKBER Age: 40Y - 3M - 7D Sex: Male

Card Holder's Tel No: Mobile No: 552691108
Ins Card No: I019-010-113228129-02 Valid Upto: 30/11/2025

Company FMC Standard Employee Name: Network No: Nationality:Pakistani



Clinical Details:	1emp36.9	B.P. <u>144</u>	Pulse. 95	
Signs & Symptoms: RISK FOR	FALL			
Date of Onset Illness :		○ Emergency ○ Work r	elated O New visit O Follow up visi	it
Diagnosis: I10 - Essential (pri	mary) hypertension, J06.9 -	Acute upper respiratory infection, unsp	ecified, R05 - Cough, R07.0 - Pain in th	hroat
Management plan (Service	OR FALL © Emergency © Work related © New visit © Follow up visit primary) hypertension, J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R07.0 - Pain in throat ices inside the clinic including injections and investigations) JTOMATED , Lab,9, Consultation Gp , General Consultation Dr. Humaira Mumtaz General Practitioner DHA No: S4155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.			
85027, COMPLETE CBC AUTO	MATED , Lab,9, Consultation	n Gp , General Consultation		
			, Am	
Doctor's Name: Humaira		cignature with scale	General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC	;

Diagnostic Procedure	s 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 08-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP	SYRUP (100ML, GLASS BOTTLE)	5	1	0.0000
(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	10	0.0000
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (24S, BLISTER PACK)	5	15	0.0000
(AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	TABLETS (30S, BLISTER)	7	7	0.0000