



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: 10-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1974-8260365-7

Card Holder's Name: LEAH OSIS YURONG

Age: 50Y - 4M - 4D Sex: Female

Card Holder's Tel No:

Mobile No:

971563093585

Ins Card No: I019-010-120688124-01

Valid Upto: 7/6/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Philippine



Clinical Details:

Temp 37.6

B.P. 122

Pulse. 111

Signs & Symptoms: RISK OF FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, unspecified

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) SOLUTION FOR INFUSION , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy, 0102-100104-1001, SODIUM CHLORIDE/PROPH/DIAG INJ SC/IM , Co.Pay, 96365, IV INFUSION THERAPY/PROPHYLAXIS , Pharmacy, 107704-0801, INFUSION INIT , Co.Pay, 9, Consultation Gp , General Consultation

Doctor's Name: AISHA

signature with seal:

Dr. Aisha U
Physician- General P
DHA- 40131439
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 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 services and copies of all medical and Clinic records.

Signature of the Patient



Date 10-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (48S, BOX)	5	15
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER)	5	10
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	3	6

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