

**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 formDate: **21-Apr-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1997-4685474-6**Card Holder's Name: **SHUBHAM YADAV TAHASELDAR** Age: **27Y - 6M - 24D** Sex: **Male**Card Holder's Tel No: _____ Mobile No: **0589532040**Ins Card No: **I005-010-117490819-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**

Clinical Details:	Temp 36.6	B.P. 129	Pulse. 78
Signs & Symptoms: RISK OF FALL			
Date of Onset Illness : _____		☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit	
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R06.2 - Wheezing, R50.9 - Fever, unspecified, R05 - Cough			

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

85027, COMPLETE CBC AUTOMATED , Lab,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0006-402803-2071, VENTOLIN NEBULES , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: **DR Amaizah**

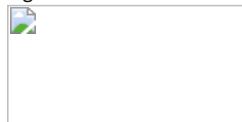
signature with seal:

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 **21-Apr-2025**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.0000
(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (9S, SACHET)	3	3	0.0000
(NAPHAZOLINE : 0.025%) (PHENIRAMINE MALEATE : 0.3%) EYE DROPS	EYE DROPS (15ML, DROPPER BOTTLE)	3	12	0.0000
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	5	1	0.0000