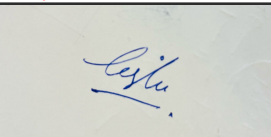


**ANNEXURE V****F M C NETWORK UAE**

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim formDate: **24-Apr-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1999-8837932-9**Card Holder's Name: **SALONI SURINDER KUMAR** Age: **25Y - 6M - 23D** Sex: **Female**Card Holder's Tel No: Mobile No: **0501964276**Ins Card No: **I005-010-121967330-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**

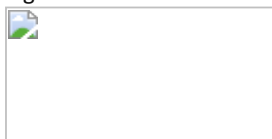
Clinical Details:	Temp 36.8	B.P. 106	Pulse. 68
Signs & Symptoms:	RISK FOR FALL		
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis: J03.90 - Acute tonsillitis, unspecified, R50.9 - Fever, unspecified, R52 - Pain, unspecified, K29.00 - Acute gastritis without bleeding			

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,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96372, THER/PROPH/DIAG INJ S Co.Pay,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,9, Consultation Gp , Genera	
Doctor's Name: AISHA	signature with seal: 
Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 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 **24-Apr-2025**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	5	10	2.2900
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10	0.0000
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	5	10	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.0000
(POVIDONE IODINE : 1%) GARGLE	GARGLE (125ML, BOTTLE)	5	5	0.0000

