

**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: 25-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1987-8304272-8

Card Holder's Name: Jennelyn Deza Arellano

Age: 37Y - 9M - 10D Sex: Female

Card Holder's Tel No:

Mobile No:

0526800421

Ins Card No: I005-010-116122173-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Philippine



Clinical Details:

Temp 37

B.P. 130

Pulse: 84

Signs & Symptoms:

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, J30.9 - Allergic rhinitis, unspecified, R52 - Pain, unspecified, R05 - Cough, E86.0 - Dehydration

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, 0102-100104-1001, SODIUM CHLORIDE/PROPH/DIAG INJ SC/IM , Co.Pay, 96361, HYDRATE IV INFUSION ADD-ON , Co. Pay, 9, Consultation Gp , General Consultation, 96374, THER/PROPH/D

Doctor's Name: AISHA

signature with seal:

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

1ST

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 25-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	10	0.0000
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	15	0.0000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	3	6	0.0000
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.0000