

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

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

Medical Expenses Claim formDate: **28-Apr-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1983-7195085-2**Card Holder's Name: **NAWROZ ALI MOHAMMAD AKBER** Age: **40Y - 3M - 27D** 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 No: \_\_\_\_\_ Nationality: **Pakistani**  
 Name: **Network**

|                                                                                                                                                                        |                  |                                                                                                                                          |                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Clinical Details:                                                                                                                                                      | Temp <b>36.9</b> | B.P. <b>137</b>                                                                                                                          | Pulse. <b>113</b> |
| Signs & Symptoms: <b>RISK FOR FALL</b>                                                                                                                                 |                  |                                                                                                                                          |                   |
| Date of Onset Illness : _____                                                                                                                                          |                  | <input type="radio"/> Emergency <input type="radio"/> Work related <input type="radio"/> New visit <input type="radio"/> Follow up visit |                   |
| Diagnosis: <b>J45.991 - Cough variant asthma, R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn, R06.2 - Wheezing, E78.5 - Hyperlipidemia, unspecified</b> |                  |                                                                                                                                          |                   |

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

**94640, AIRWAY INHALATION TREATMENT , Co.Pay,0006-402803-2071, VENTOLIN NEBULES , Pharmacy,9, Consultation Gp , General Consultation,82465, ASSAY BLD/SERUM CHOLESTEROL , Lab,84478, ASSAY OF TRIGLYCERIDES , Lab**

Doctor's Name: **DR Amaizah**

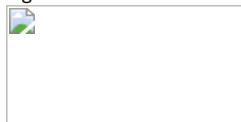
signature with seal:

**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 **28-Apr-2025****Pharmaceuticals (to be filled by treating doctor only)**

| Medicine                                              | Dose                                         | Duration | Quantity | Price  |
|-------------------------------------------------------|----------------------------------------------|----------|----------|--------|
| (BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION | SUSPENSION FOR NEBULIZATION (2ML X 20, UNIT) | 2        | 4        | 0.0000 |
| (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP           | SYRUP (100ML, BOTTLE)                        | 7        | 1        | 0.0000 |
| (MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS | FILM COATED TABLETS (28S, BLISTER PACK)      | 7        | 7        | 0.0000 |