

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

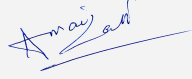
P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim form

Date: 30-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1987-0974286-4
Card Holder's Name: MOUSTAFA MOHAMED YASSIN Age: 38Y - 0M - 3D Sex: Male
Card Holder's Tel No: Mobile No: 0507279947
Ins Card No: 1005-010-122064419-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: Nationality: Egyptian



Clinical Details:	Temp 37.6	B.P. 120	Pulse. 78
Signs & Symptoms:	RISK FOR FALL		
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis:	R21 - Rash and other nonspecific skin eruption, R50.9 - Fever, unspecified, J02.9 - Acute pharyngitis, unspecified, B01.9 - Varicella without complication		

Management plan (Services inside the clinic including injections and investigations)	
85027, COMPLETE CBC AUTOMATED , Lab, 0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy, 0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 9, Consultation Gp , General Consultation, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 0439 Pharmacy, 96361, HYDRATE IV INFUSION ADD-ON , Co.Pay	
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 30-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(ACYCLOVIR : 400 MG) TABLETS	TABLETS (35S, BLISTER PACK)	7	14	0.0000
(CALAMINE : 15 G/100ML) (ZINC OXIDE : 5 G/100ML) (PHENOL : 0.5 G/100ML) (BENTONITE : 3 G/100ML) LOTION	LOTION (1S, PLASTIC BOTTLE)	7	1	0.0000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000
(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	5	10	0.0000