

Pharmaceuticals (to be filled by treating doctor only)

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 Emirates: 784-2003-7812501-5 Clinic Name: CITICARE MEDICAL CENTER LLC Card Holder's Name: SALMA RAAH KATSANDE Age: 21Y - 4M - 17D Sex: Female 0521994716 Card Holder's Tel No: Mobile No: Ins Card No: 1005-010-121967329-01 Valid Upto: 30/9/2025 **FMC Standard** Company **Employee** Nationality: Zimbabwean Name: Network No: Clinical Details: B.P.130 Temp36.8 Pulse. 78 Signs & Symptoms: RISK FOR FALL Date of Onset Illness: ○ Emergency ○ Work related ○ New visit ○ Follow up v Diagnosis: R03.0 - Elevated blood-pressure reading, w∕o diagnosis of htn, R52 - Pain, unspecified, R50.9 - Fever, unspecified, R10.8∠ Generalized abdominal pain Management plan (Services inside the clinic including injections and investigations) 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,82948, REAGENT STRIP/BLOOD GLUCOSE, Lab,0046-149902-0511, (DICLOFENAC SODIUM: 75 MG/3ML) INJECTION, Pharmacy,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /D> 1 HR, Co.Pay Dr. Amaizah Ishtiag General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENT DUBAI - U.A.E Doctor's Name: DR Amaizah signature with seal: 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 an person who has provided medical services to me to furnish any and all information with regard to any medical history, medical conc medical services and copies of all medical and Clinic records. Signature of the Patient Date 30-Apr-2025