

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: 784-1996-4706085-6 Card Holder's Name: SAMIRA NJAMBI KINYANJUI Age: 29Y - 2M - 21D Sex: Female Card Holder's Tel No: Mobile No: 0503767982
Ins Card No: 1005-010-122176933-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: ______Nationality: Kenyan



Clinical Details:	Temp36.1	B.P.120	Pulse. 84		
Signs & Symptoms: risk of	'				
Date of Onset Illness:		○ Emergency ○ Worl	○ Emergency ○ Work related ○ New visit ○ Follow up visit		
Diagnosis: R25.2 - Cramp a	nd spasm, R52 - Pain, unspeci	fied	•		
			•		
Management plan (Service	ces inside the clinic including i	njections and investigations)			
_ , ,		• • •	COMPLETE CBC AUTOMATED , Lab,9,		
_ , ,	N , Pharmacy,96372, THER/PF	• • •	COMPLETE CBC AUTOMATED , Lab,9,		
0005-149902-1021, CLOFE	N , Pharmacy,96372, THER/PF	• • •	COMPLETE CBC AUTOMATED , Lab,9,		

hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the abovementioned 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)

That made a decide for the day area and a decide only)							
Medicine	Dose	Duration	Quantity	Price			
(IBUPROFEN : 400 MG) TABLETS	TABLETS (120S, BOX)	5	10	0.0000			
(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000			
(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (50G, TUBE)	5	1	0.0000			