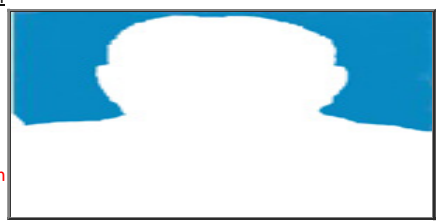
ANNEXURE V

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: 07-May-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-5449778-7
Card Holder's Name: HASAN MOHD HAYATH Age: 25Y - 1M - 22D Sex: Male
Card Holder's Tel No: Mobile No: +97470826887
Ins Card No: I005-010-119768244-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.4 B.P.120 Pulse. 68
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: H01.006 - Unspecified blepharitis left eye, unspecified eyelid, R21 - Rash and other nonspecific skin eruption, R52 - Pain, unspecified

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

85027, COMPLETE CBC AUTOMATED , Lab,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , 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 07-May-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(DEXAMETHASONE : 1 MG/G) (NEOMYCIN : 3500 IU/G) (POLYMYXIN B : 6000 IU/G) EYE OINTMENT	EYE OINTMENT (3.5G, TUBE)	5	5	10.5000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	3	3	0.0000