

**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 formDate: **18-May-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1999-2541562-4**Card Holder's Name: **YARA HASSAN ALI KHEDR** Age: **26Y - 3M - 20D** Sex: **Female**Card Holder's Tel No: Mobile No: **0508437137**Ins Card No: **I005-010-121951170-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Egyptian**Clinical Details: Temp **37.3** B.P. **140** Pulse. **123**Signs & Symptoms: **RISK FOR FALL**Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ FollowDiagnosis: **J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, J30.9 - Allergic rhinitis, unspecified, R06.2 - Wheezing, unspecified, Acute tonsillitis, unspecified**Management plan (Services inside the clinic including injections and investigations)

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 85027, COMPLETE CBC AUTOMATED , Lab, 0046-111801-0511, (CHLORPHENIRAMINE : 1 MG/ML) INJECTION , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 3RD DAY, Co.Pay, 9, Consultation Gp , General Consultation

Doctor's Name: **DR Amaizah**

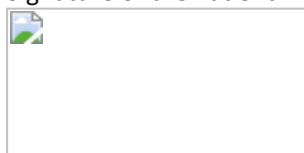
signature with seal:

Dr. Amaizah I
 General Practitioner
 DHA: 98486553
CITICARE MEDICAL
 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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **18-May-2025**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	5
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10
(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	3	6

