

**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: **31-May-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1995-2615750-0**Card Holder's Name: **LOKESH BHATTARAI KESHAB BAHADUR KHATRI** Age: **30Y - 4M - 0D** Sex: **Male**Card Holder's Tel No: Mobile No: **0564911539**Ins Card No: **I005-010-120916688-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: Nationality: **Nepalese**

Clinical Details:	Temp 39.2	B.P. 120	Pulse. 88
Signs & Symptoms: RISK FOR FALL			
Date of Onset Illness :		☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit	
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, E86.0 - Dehydration, R52 - Pain, 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,0005-149902-1021, CLOFEN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,9, Consultation Gp , General Consultation

Doctor's Name: **DR Amaizah**

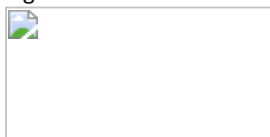
signature with seal:

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

Medicine	Dose	Duration	Quantity	Price
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	7	14	0.0000
(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER)	3	6	0.0000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000
(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	SYRUP (120ML, BOTTLE)	5	1	0.0000