

**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: **03-Jun-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1995-2615750-0**Card Holder's Name: **LOKESH BHATTARAI KESHAB BAHADUR KHATRI** Age: **30Y - 4M - 3D** Sex: **Male**Card Holder's Tel No: Mobile No: **0564911539**Ins Card No: **I005-010-120916688-01** Valid Upto: **30/9/2025**Company: **FMC Standard** Employee No: _____ Nationality: **Nepalese**

Clinical Details:	Temp 40	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, R52 - Pain, unspecified, R11.0 - Nausea, E86.0 - Dehydration			

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,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,9.01, Free Follow-Up Consultation Gp , General Consultation,96 TX/PRO/DX INJ NEW DRUG ADDON , Co.Pay,96361, HYDRATE IV INFUSION ADD-ON

Doctor's Name: **Dr.Farhan Ilyas**

signature with seal:

Dr .Farhan Ilyas Malik
 Physician-General Practitioner
 DHA-06441782-001
 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 **03-Jun-2025****Pharmaceuticals (to be filled by treating doctor only)**

Medicine	Dose	Duration	Quantity	Price
(PARACETAMOL : 600 MG) (PHENYLEPHRINE HCL : 10 MG) ORAL POWDER	ORAL POWDER (10S, SACHET)	5	15	0.0000
(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	10	0.0000
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	5	1	0.0000
(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000