

## 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:	12-	lun-2	2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-7438900-2 Card Holder's Name: Janet Muthoki Peter Age: 26Y - 7M - 29D Sex: Female

Card Holder's Tel No: Mobile No: 0543546130
Ins Card No: I019-010-122062355-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: \_\_\_\_\_\_Nationality: Kenyan



Clinical Details:	Temp36.5	B.P.126	Pulse. 78
Signs & Symptoms: RISK ( Date of Onset Illness:	OF FALL	○ Emergency ○ Wo	ork related O New visit O Follow up visit
Diagnosis: N94.6 - Dysme vaginitis, R52 - Pain, unsp		- Nausea with vomiting, unspecified, R	RSO.9 - Fever, unspecified, N76.0 - Acute
Management plan (Serv	vices inside the clinic includin	g injections and investigations)	
1 '	UTOMATED , Lab,0135-14990 C/IM , Co.Pay,9, Consultation		1G/3ML) INJECTION , Pharmacy,96372,
Doctor's Name: DR Ama	izah	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 12-Jun-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, STRIP)	7	14	0.0000