

**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: 18-Jul-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1979-3087639-2
Card Holder's Name: MIRZA ZEESHAN BABAR Age: 45Y - 7M - 18D Sex: Male
Card Holder's Tel No: Mobile No: 0558485913
Ins Card No: I019-010-119760970-02 Valid Upto: 7/6/2026
Company: FMC Standard Employee No: _____ Nationality: Pakistani
Name: Network



Clinical Details: Temp 37.5 B.P. 160 Pulse: 78
Signs & Symptoms: risk of fall
Date of Onset Illness : _____
☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough, R52 - Pain, unspecified, E86.0 - Dehydration, M54.5 - Low back pain, R06.2 - Wheezing

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy, 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZ TREATMENT , Co.Pay, 9, Consultation Gp , General Consultation, 96374, THER/PROF INJ SC/IM , Co.Pay

Doctor's Name: AISHA

signature with seal:

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
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 18-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (48S, BOX)	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
(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	5	10	0.0000