

**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: **19-Jul-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-2003-3461381-5**Card Holder's Name: **AHMAD KHEDR ABDO** Age: **22Y - 0M - 2D** Sex: **Male**Card Holder's Tel No: Mobile No: **0553571014**Ins Card No: **I019-010-122016139-02** Valid Upto: **7/6/2026**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Syrian**Clinical Details: Temp **36.6** B.P. **131** Pulse. **65**

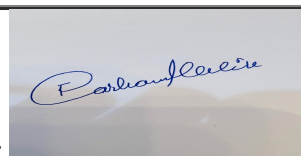
Signs & Symptoms:

Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ FollowDiagnosis: **J02.9 - Acute pharyngitis, unspecified, R52 - Pain, unspecified, J30.89 - Other allergic rhinitis**

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

9, Consultation Gp , General ConsultationDoctor's Name: **Dr.Farhan Iyas**

signature with seal:

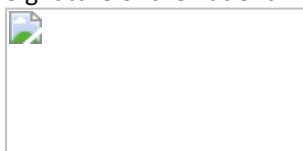


Dr .Farhan Ilyas
 Physician-General F
 DHA-0644178;
 CITICARE MEDICAL
 DUBAI U.A.E

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 **19-Jul-2025**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(SODIUM AESCINATE : 20 MG) TABLETS	TABLETS (40S, BOX)	5	10
(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	10
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10