

## 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

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Date:	<i>//-</i>	ш	ーノ	()/	'5

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1985-5394869-0 Card Holder's Name:IRFAN SHAFFI MUHAMMAD SHAFFIAge:39Y - 7M - 24DSex:Male

Card Holder's Tel No: Mobile No: 0524544336

Ins Card No: 1005-010-117977933-01 Valid Upto: 30/9/2025
Company FMC Standard Employee

Name: Network No: \_\_\_\_\_Nationality:Pakistani



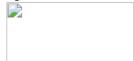
Clinical Details:	Temp <mark>37.6</mark>	B.P. <mark>150</mark>	Pulse. <mark>90</mark>
Signs & Symptoms: RISK (	OF FALL		
Date of Onset Illness:		○ Emergency ○ Wo	rk related O New visit O Follow up visit
Diagnosis: J30.9 - Allergio	rhinitis, unspecified, R50.9 - F	ever, unspecified, R52 - Pain, unspeci	fied, R05 - Cough
Management plan (Serv	vices inside the clinic including	; injections and investigations)	
2190-106618-1001, PARA	FUSIV I.V. 10MG/ML-(PARACE	TAMOL: 10 MG/ML) SOLUTION FOR I	NFUSION , Pharmacy,0005-111805-1021,
CHLOROHISTOL 10MG-(C	HLORPHENIRAMINE MALEATE	: 10 MG/ML) SOLUTION FOR INJECTION	ON , Pharmacy,85027, COMPLETE CBC
AUTOMATED , Lab,9, Con	sultation Gp , General Consult	ation,96374, THER/PROPH/DIAG INJ I	V PUSH , Co.Pay,96372, THER/PROPH/DIAG INJ
SC/IM , Co.Pay			د. کیرثانا رانی بادیبورایل ثارا Dr. Keerthana Rani Padippurayil Thara General Practitioner License No.: 37864046-001 مرکز سیتیکیر الطبی ذم م
Doctor's Name: KEERTH	ΔΝΔ	signature with seal:	CITICARE MEDICAL CENTER LLC

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 27-Jul-2025



## Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price	
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	3	12	0.0000	
(DESLORATADINE : 5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	5	5	0.0000	
(OXOMEMAZINE : 0.33 MG/ML) SYRUP	SYRUP (150ML, PLASTIC BOTTLE)	5	75	0.0000	