

ANNEXURE V

FMCNETWORKUAE

P. O. BOX: 50430, DUBAI, **Tel – 04 3871900, Fax – 04 3977842 Email – approval@fmchealthcare.ae Helpline Number: 600-565691**

Medical Expenses Claim form

| Date: | 29-1 | ш | 1-21 | 025 |
|-------|------|---|------|-----|
| Date. | 200 | u | | 023 |

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1972-6585952-6
Card Holder's Name: MONIA BEN NEJMA EP ALIJABI Age:52Y - 7M - 19D Sex:Female

Card Holder's Tel No: Mobile No: 0501465907
Ins Card No: I038-010-118639628-01 Valid Upto: 1/9/2025
Company Name: FMC Standard Network Employee No: Nationality: Tunisian



| Clinical Details: | Temp36.4 | B.P. <mark>110</mark> | Pulse. 70 |
|--------------------------|--------------------------|--|-----------------------------------|
| Signs & Symptoms: RISI | K FOR FALL | | |
| Date of Onset Illness : | | ○ Emergency ○ Wor | k related O New visit O Follo |
| Diagnosis: R79.82 - Elev | vated C-reactive protein | (CRP), N39.0 - Urinary tract infection, site not | specified, R52 - Pain, unspecifie |
| Lower abdominal pain | unspecified | | |

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,9 INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,81015, MICROSCOPIC EXAM OF URINE , Lab,96372, THER/PROPH SC/IM , Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.Pay

Portronfloreire

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

Doctor's Name: Dr.Farhan lyas signature with seal:

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 medical services and copies of all medical and Clinic records.

Signature of the Patient



Date 29-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quan |
|---|--|----------|------|
| (CIPROFLOXACIN : 250 MG) FILM COATED TABLETS | FILM COATED TABLETS (10S, BLISTER PACK) | 5 | 10 |
| (SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES | EFFERVESCENT GRANULES (4G X 10, SACHET) | 5 | 10 |
| (SERRAPEPTASE : 10 MG) TABLETS | TABLETS (30S, BLISTER) | 5 | 10 |