



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: 31-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1986-2764743-5
Card Holder's Name: MOHAMED HASSAN MOHAMED Age: 39Y - 1M Sex: Male
Name: ABDELRAHMAN ELSAADANY - 5D
Card Holder's Tel No: Mobile No: 0523543663
Ins Card No: I019-010-120233657-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: Nationality: Egyptian



Clinical Details:	Temp 36.6	B.P. 140	Pulse. 81
Signs & Symptoms: RISK OF FALL			
Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit			
Diagnosis: A05.9 - Bacterial foodborne intoxication, unspecified, R50.9 - Fever, unspecified, E86.0 - Dehydration, R11.2 - Nausea with vomiting, unspecified, R12 - Heartburn, R19.7 - Diarrhea, unspecified, K29.00 - Acute gastritis without bleeding, R10.84 - Generalized abdominal pain			

Management plan (Services inside the clinic including injections and investigations)	
85025, COMPLETE CBC W/AUTO DIFF WBC, Lab, 2568-242802-0601, (PANTOPRAZOLE (AS SODIUM)) : 40 MG) LYOPHILIZED POWDER FOR INJECTION, Pharmacy, 96361, HYDRATE IV INFUSION ADD-ON, Co. Pay, 0439-152905-1001, LACTATED RINGERS INJECTION USP, Pharmacy, 96374, THER/PROPH/DIAG INJ IV PUSH, Co. Pay, 0005-136504-1021, SCOPINAL, Pharmacy, 0005-150403-1021, PREMOSAN, Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM, Co. Pay, 0135-116611-1001, (MET Pharmacy, 9, Consultation Gp, General Consultation	
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 31-Jul-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(ESOMEPRAZOLE (AS MAGNESIUM)) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14	2.2900
(METOCLOPRAMIDE : 10 MG) TABLETS	TABLETS (20S, BOX)	5	10	0.0000
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000
(SODIUM CHLORIDE : 2.6 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) (DEXTRROSE ANHYDROUS : 13.5 G) POWDER FOR SOLUTION	POWDER FOR SOLUTION (10X21.8G, SACHET)	3	6	0.0000
(ALUMINIUM HYDROXIDE : 225 MG/5ML) (SIMETHICONE : 25 MG/5 ML) (MAGNESIUM HYDROXIDE : 200 MG/5ML) SUSPENSION	SUSPENSION (180ML, PLASTIC BOTTLE)	5	10	0.0000