

**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: **01-Aug-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1987-8304272-8**Card Holder's Name: **Jennelyn Deza Arellano**Age: **38Y - 0M - 17D** Sex: **Female**

Card Holder's Tel No:

Mobile No: **0526800421**Ins Card No: **I005-010-116122173-01**Valid Upto: **30/9/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Philippine**

Clinical Details:

Temp **36.8**B.P. **130**Pulse. **70**Signs & Symptoms: **RISK OF FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

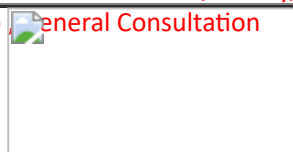
Diagnosis: **K29.00 - Acute gastritis without bleeding, R07.0 - Pain in throat, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R Dysphonia**

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

0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Phar 135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,0005-242802-0781, PAN I.V. , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,94640, AIRWAY INHALATION TREATMENT , Co.Pay,96374, THER/PRO IV PUSH , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: **KEERTHANA**

signature with seal:

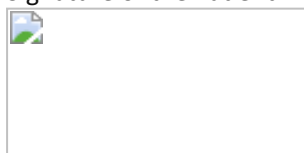


راني باديورايل ثارا
 Dr. Keerthana Rani Padip
 General Practi
 License No.: 37864
 يتكبير الطبي ذم م
 CITICARE MEDICAL C

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 **01-Aug-2025**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	1
(DESLORATADINE : 5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	5	5
(OXOMEMAZINE : 0.33 MG/ML) SYRUP	SYRUP (150ML, PLASTIC BOTTLE)	5	150

Medicine	Dose	Duration	Quantity
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	5	5