

## 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: 11-Aug-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1990-7131498-5
Card Holder's Name: YAM RAJ GIRI Age: 34Y - 11M - 0D Sex: Male

 Card Holder's Name:
 YAM RAJ GIRI
 Age:
 34Y - 11M - 0D
 Sex:
 Male

 Card Holder's Tel No:
 Mobile No:
 0502318389

 Ins Card No:
 1005-010-116653001-01
 Valid Upto:
 30/9/2025

Company FMC Standard Employee Name: Network No:



Clinical Details:	Temp <mark>36.7</mark>	B.P. <b>110</b>	Pulse. <mark>84</mark>
Signs & Symptoms: RISK OF FA	ALL		
Date of Onset Illness :		○ Emergency ○ Work related ○ New visit ○ Follow up v	
Diagnosis: J00 - Acute nasoph	aryngitis [common cold], F	850.9 - Fever, unspecified, J30.89 - O	other allergic rhinitis, 195.9 - Hypotension,
unspecified, R07.0 - Pain in th	roat, R05 - Cough		

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96375, TX/PRO/DX INJ NEW DRUG ADDON , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372,

THER/PROPH/DIAG INJ SC/IM, Co.Pay,0439-152905-1001, LACTATED RINGERS INJI INIT, Co.Pay,9, Consultation Gp, General Consultation

Leglu.

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

NC

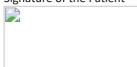
Doctor's Name: AISHA signature with seal:

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 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 11-Aug-2025



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

Medicine	Dose	Duration	Quantity	Price
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER PACK)	5	10	0.0000
(IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY	NASAL SPRAY ( 10ML, HDPE BOTTLE METERED DOSE SPRAY PUMP)	4	8	0.0000
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	15	0.0000
(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	SYRUP (120ML, BOTTLE)	5	10	0.0000