

**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: **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 Tel No: Mobile No: **0502318389**Ins Card No: **I005-010-116653001-01** Valid Upto: **30/9/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Nepalese**

Clinical Details:

Temp **36.7**B.P. **110**Pulse: **84**Signs & Symptoms: **RISK OF FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis: **J00 - Acute nasopharyngitis [common cold], R50.9 - Fever, unspecified, J30.89 - Other allergic rhinitis, I95.9 - Hypotension, unspecified, R07.0 - Pain in throat, 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 INJ INIT , Co.Pay,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 **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