

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:	21-	٩uɐ	:-20	25
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Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-6574048-1
Card Holder's Name: MOHD ARIF QRESHI MOHD ALTAB Age: 31Y - 10M - 16DSex: Male

Card Holder's Tel No: Mobile No: 567062668

Ins Card No: 1005-010-122975455-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: ______ Nationality: Indian



Clinical Details:	Temp <mark>36.6</mark>	B.P. <mark>120</mark>	Pulse. 100
Signs & Symptoms: RISK C	F FALL		
Date of Onset Illness:		○ Emergency ○ Work	related O New visit O Follo
Diagnosis: J06.9 - Acute u	oper respiratory infection, uns	specified, R50.9 - Fever, unspecified, R0	7.0 - Pain in throat, R05 - Coug
Other allergic rhinitis, E86	.0 - Dehydration		

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) § FOR INFUSION , Pharmacy,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PH Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372,

signature with seal:

THER/PROPH/DIAG INJ SC/IM, Co.Pay,0384-111908-1001, SODIUM CHLORIDE B.P. Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH, Co.Pay,9, Consultation Gp, Genera

Lesta.

Dr. Aisha U Physician- General P DHA- 40131439 CITICARE MEDICA DUBAI - U.A

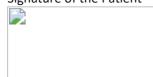
Diagnostic Procedures referred outside:

Doctor's Name: AISHA

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 21-Aug-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (48S, BOX)	5	10
(AZITHROMYCIN: 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER PACK)	5	10
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	5	10

Medicine	Dose	Duration	Quan
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	10