



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-Aug-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-6574048-1

Card Holder's Name: MOHD ARIF QRESHI MOHD ALTAB Age: 31Y - 10M - 16D Sex: Male

Card Holder's Tel No: Mobile No: 567062668

Ins Card No: I005-010-122975455-01 Valid Upto: 30/9/2025

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



Clinical Details: Temp 36.6 B.P. 120 Pulse. 100

Signs & Symptoms: RISK OF FALL

Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R07.0 - Pain in throat, R05 - Cough
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) SOLUTION FOR INFUSION , Pharmacy, 96361, HYDRATE IV INFUSION ADD-ON , Co.Pay, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE INJECTION , Pharmacy, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0384-111908-1001, SODIUM CHLORIDE B.P. 0.9% INJECTION , Pharmacy, 96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay, 9, Consultation Gp , General Practitioner

Doctor's Name: AISHA

signature with seal:

Dr. Aisha U
Physician- General P
DHA- 40131439
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 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 21-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)

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