



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

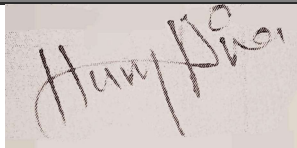
Medical Expenses Claim form

Date: **23-Aug-2024**

Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1991-8981152-6**
Card Holder's Name: **SHYMON JOHN JOHN MATHEW** Age: **33Y - 5M - 5D** Sex: **Male**
Card Holder's Tel No: _____ Mobile No: **0562156177**
Ins Card No: **I019-010-118001770-01** Valid Upto: **7/6/2025**
Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**



Clinical Details:	Temp 36.5	B.P. 120	Pulse. 66
Signs & Symptoms: Risk of Fall			
Date of Onset Illness : _____		☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit	
Diagnosis: R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough			

Management plan (Services inside the clinic including injections and investigations)	
9, Consultation Gp , General Consultation, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION , Pharmacy, 0125-122107- 1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy	
Doctor's Name: Humaira	signature with seal:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC 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 23-Aug-2024

A large rectangular box with a thin border, intended for the patient's signature.

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	5	5	0.0000
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	3	6	0.0000
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	1	1	0.0000