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: 25-Jul-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-5106535-6
Card Holder's Name: ROMESH SHALITHA SILVA MIHIDU KULASOORIYA WARNA PELILAGE Age: 31Y - 3M - 4D Sex: Male
Card Holder's Tel No: Mobile No: 0501709652
Ins Card No: I019-010-118984990-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 36.9 B.P. 92 Pulse. 103
Signs & Symptoms: risk for fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, J00 - Acute nasopharyngitis [commo Cough, R51.9 - Headache, unspecified

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

0095-107701-0801, (CEFTRIAXONE : 1000 MG) POWDER FOR INJECTION , Pharmacy,0442-106618-1001, (PARACETAMOL : 10 M SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0125-122107-102 DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/P INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation,96374, THER/PROPH/

Dr. Enomen Goodl
General Practiti
DHA No: 280408
CITICARE MEDICAL C
DUBAI - U.A

Doctor's Name: Enomen Goodluck 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 ab mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy c person who has provided medical services to me to furnish any and all information with regard to any medical history, medical c medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 25-Jul-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	5	1
CETIRIZINE HCL	Tablet	5	5
(CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET	CAPLET-TABLET (30S, BLISTER)	5	10

Medicine	Dose	Duration	Quant
(TULSI (OCIMUM SANCTUM) : 100 MG/10ML) (ADHATODA VASICA : 100 MG/10ML) (VIOLA ODORATA : 75 MG/10ML) (CURCUMA LONGA : 25MG/10ML) (ELETTARIA CARDAMOMUM : 25MG/10ML) (GLYCYRRHIZA GLABRA : 100 MG/10ML) (SOLANUM XANTHOCARPUM : 75 MG/10ML) (PIPER LONGUM : 25MG/10ML) (ZINGIBER OFFICINALE : 50MG/10ML) (DALCHINI : 10 MG/10ML) (SYZYGIUM AROMATICUM : 10 MG/10ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, BOTTLE)	5	10