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: 06-Sep-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1983-7397594-9
Card Holder's Name: JUDILYN TORRES DELA ROSA Age: 41Y - 2M - 20D Sex: Female
Card Holder's Tel No: Mobile No: 0503281217
Ins Card No: I019-010-118489752-01 Valid Upto: 8/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Philippine

Clinical Details: Temp 37.3 B.P. 178 Pulse. 86
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: G43.009 - Migraine w/o aura, not intractable, w/o status migrainosus, K29.00 - Acute gastritis without bleeding, R50.9 - Fever, unspecified, J06.9 - Acute upper respiratory infection, unspecified

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

9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy

Doctor's Name: Enomen Goodluck signature with seal:

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
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 06-Sep-2024

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quantity | Price |
|---|---|---|---|---|
| (DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION | POWDER FOR SOLUTION (30S, SACHET) | 4 | 16 | 0.0000 |
| (SUMATRIPTAN (AS SUCCINATE) : 100 MG) FILM COATED TABLETS | FILM COATED TABLETS (2S, BLISTER PACK) | 5 | 5 | 0.0000 |
| (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS | FILM COATED TABLETS (10S, BLISTER PACK) | 10 | 10 | 0.0000 |
| (PREDNISOLONE : 5 MG) TABLETS | TABLETS (20S, BLISTER PACK) | 5 | 10 | 0.0000 |
| (AZITHROMYCIN : 500 MG) FILM COATED TABLETS | FILM COATED TABLETS (6S, BLISTER) | 6 | 6 | 0.0000 |