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

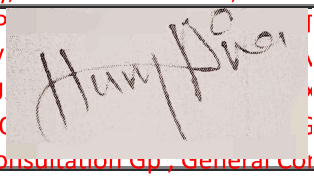
Medical Expenses Claim form

Date: 29-Sep-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1994-8818795-8
Card Holder's Name: AYE THINZAR OO Age: 29Y - 11M - 20D Sex: Female
Card Holder's Tel No: Mobile No: 0547662804
Ins Card No: I019-010-118372812-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Myanmarese

Clinical Details: Temp37.4 B.P.124 Pulse. 82
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, K29.00 - Acute gastritis v bleeding, J30.9 - Allergic rhinitis, unspecified

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,2190-106618-1001, PARAFUSIV I. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1S HR , Co.Pay,96372, THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, PRESSURIZED/NONP 107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,2190-106618-1001, PARAFUSIV FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,96365, IV INFU Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0188-135906-2441, PULMIC NEBULIZATION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,9, Consultation Gp , General Consultation



Dr. Humaira Mumta
General Practitioner
DHA No: 54155530-00
CITICARE MEDICAL CENTE
DUBAI - U.A.E.

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

Signature of the Patient

Date 29-Sep-2024

Pharmaceuticals (to be filled by treating doctor only)

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

Medicine	Dose	Duration	Quantity
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER)	7	7
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	1	1