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

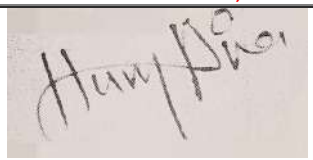
Date: 06-Dec-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1994-1879457-6
Card Holder's Name: KULDEEP CHAND RAMOLA DAYAL CHAND RAMOLA Age: 30Y - 11M - 8D Sex: Male
Card Holder's Tel No: Mobile No: 0558683213
Ins Card No: I005-010-120104392-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 36.7 B.P. 111 Pulse. 115
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, K29.00 - Acute gastritis without bleeding

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLU
INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM
Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRWAY
INHALATION TREATMENT , Co.Pay,9, Consultation Gp , General Consultation

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 06-Dec-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) | 10 | 10 |

| Medicine | Dose | Duration | Quantity |
|---|---|---|---|
| (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS | TABLETS (14S, BLISTER PACK) | 7 | 7 |
| (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS | CAPLETS (24S, BOX) | 6 | 12 |
| (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE | SYRUP (SUGAR FREE (120ML, BOTTLE | 1 | 1 |
| (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES | DELAYED RELEASE CAPSULES (30S, CONTAINER) | 7 | 14 |