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

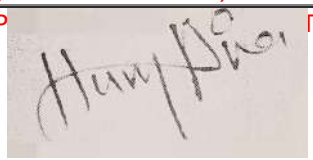
Date: 12-Dec-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-8884170-3
Card Holder's Name: AUNG KO KO Age: 24Y - 1M - 17D Sex: Male
Card Holder's Tel No: +959954009721 Mobile No: 0522642679
Ins Card No: I005-010-119448898-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network 3 Employee No: _____Nationality:Myanmarese

Clinical Details: Temp37.7 B.P.122 Pulse. 111
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R50.9 - Fever, unspecified, K29.00 - Acute gastritis v bleeding

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,000 149902-1021, CLOFEN , Pharmacy,96372, THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM , Co.Pay,2190-106618-1001, PAR I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0188-135906-2441, PULMICORT-(BUDESONIDE MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, PRESSURIZED/NONP I 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 12-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)	5	5

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