

**ANNEXURE V****F M C NETWORK UAE**

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842  
 Email – [approval@fmchealthcare.ae](mailto:approval@fmchealthcare.ae) Helpline Number: 600-565691

Medical Expenses Claim form

Date: 18-Dec-2024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-5928028-6

Card Holder's LAKSHAN DINUJAYA

Name: WICKRAMASEKARA

Age: 29Y - 3M - 22D Sex: Male

Card Holder's Tel No: Mobile No: 0543882005

Ins Card No: I019-010-119800664-01 Valid Upto: 7/6/2025

Company FMC Standard Employee Sri  
 Name: Network No: Nationality: Lankan

Clinical Details: Temp 37.8 B.P. 140 Pulse. 80

Signs &amp; Symptoms: RISK FOR 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 - Fainting, unspecified, K29.00 - Acute gastritis without bleeding

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

0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 0195-10  
 CEFTRIAXONE-TABUK IV , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML)  
 FOR INFUSION , Pharmacy, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay, 96372, THER/F  
 INJ SC/IM , Co.Pay, 0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/3ML) SOLUTION FOR INHALATION  
 Pharmacy, 94640, AIRWAY INHALATION TREATMENT , Co.Pay, 9, Consultation  
 INJ IV PUSH , Co.Pay

Doctor's Name: Humaira

signature with seal:

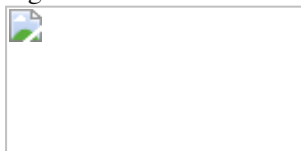
Dr. Humaira N  
 General Practitioner  
 DHA No: 541551  
 CITICARE MEDICAL  
 DUBAI - U.A.E.

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 examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 18-Dec-2024

Pharmaceuticals (to be filled by treating doctor only)

| Medicine                                          | Dose                                    | Duration | Quantity |
|---------------------------------------------------|-----------------------------------------|----------|----------|
| (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS | CAPLETS (24S, BOX)                      | 6        | 12       |
| (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS      | FILM COATED TABLETS (10S, BLISTER PACK) | 5        | 5        |
| (AZITHROMYCIN : 500 MG FILM COATED TABLETS        | FILM COATED TABLETS (3S, BLISTER        | 7        | 7        |

| Medicine                                                      | Dose                                    | Duration | Quantity |
|---------------------------------------------------------------|-----------------------------------------|----------|----------|
| (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG<br>CAPSULES (HARD GELATIN | CAPSULES (HARD GELATIN<br>(14S, BLISTER | 7        | 14       |
| (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR<br>FREE           | SYRUP (SUGAR FREE (120ML,<br>BOTTLE     | 1        | 1        |