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

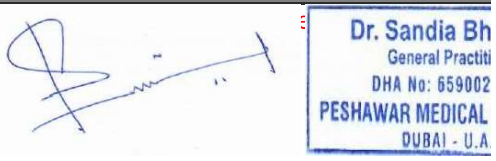
Medical Expenses Claim form

Date: 14-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-2395675-1
Card Holder's Name: ADITYA KUMAR SHIVCHANDRA THAKUR Age: 25Y - 11M - 11D Sex:Male
Card Holder's Tel No: Mobile No: 0509502547
Ins Card No: I005-010-120929342-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.4 B.P.120 Pulse. 82
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: J02.9 - Acute pharyngitis, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, R09.81 - Nasa

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,2190-106618-1001, I
I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS
1 HR , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-
PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharm



Doctor's Name: SANDIA 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 mentioned 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, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 14-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	7
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (200S, BLISTER PACK)	7	7
(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	7	14

Medicine	Dose	Duration	Quan
(DEXTROMETHORPHAN : 30 MG) (PARACETAMOL : 650 MG) (PSEUDOEPHEDRINE : 60 MG) GRANULES FOR RECONSTITUTION	GRANULES FOR RECONSTITUTION (20G X 6, SACHET)	6	6
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(OXOMEMAZINE : 0.33 MG/ML) SYRUP	SYRUP (150ML, PLASTIC BOTTLE)	10	1