

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: | 31 | - | lar | 1-2 | 025 |
|-------|----|-----|-----|-----|-----|
| Date. | | _ , | uı | - | 023 |

Emirates: 784-2004-4594930-6 Clinic Name: CITICARE MEDICAL CENTER LLC

Age: 21Y - 1M Sex: Male Card Holder's KAVINDU MADURANGA WEERAKOON WEERAKOON MUDIYANSELAGE Name:

Card Holder's Tel No: Mobile No: 971561132920

Ins Card No: 1005-010-120341564-01 Valid Upto: 30/9/2025 _Nationality: Lankan Company **FMC Standard** Employee

Name: Network No:

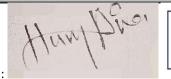


| Clinical Details: | Temp <mark>37.2</mark> | B.P. <mark>122</mark> | Pulse. <mark>86</mark> | |
|--------------------------|-------------------------------|---|--------------------------------------|-----|
| Signs & Symptoms: RIS | K OF FALL | | | |
| Date of Onset Illness: | | ○ Emergency ○ Wor | k related O New visit O Follow up vi | sit |
| Diagnosis: IO6 9 - Acute | unner respiratory infection u | nspecified 130.9 - Allergic rhinitis unsp | ecified R50.9 - Fever unspecified | |

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

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:



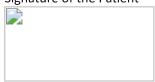
General Practitioner CITICARE MEDICAL CENTER LLC

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

Signature of the Patient

Date 31-Jan-2025



Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quantity | Price |
|---|---|----------|----------|---------|
| (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS | FILM COATED TABLETS (10S, BLISTER PACK) | 5 | 5 | 0.0000 |
| (AZITHROMYCIN: 500 MG FILM COATED TABLETS | FILM COATED TABLETS (3S, BLISTER | 5 | 5 | 10.8300 |
| (CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS | CAPLETS (24S, BOX | 6 | 12 | 0.0000 |