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

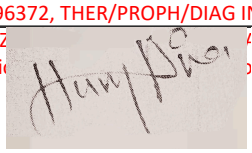
Date: 03-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1992-8024213-4
Card Holder's Name: PATHUM DHARSHANA HEWA GAMANAYAKAGE Age: 32Y - 7M - 28D Sex: Male
Card Holder's Tel No: Mobile No: 0527401520
Ins Card No: I005-010-116652995-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 37.7 B.P. 130 Pulse. 106
Signs & Symptoms: Risk of Fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
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)

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , 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 NEBULIZ[illegible] TREATMENT , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9, Consultati[illegible]

Doctor's Name: Humaira signature with seal:



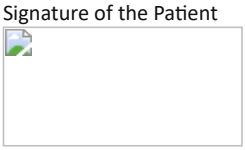
Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

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 above-mentioned 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 03-Feb-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	7	7	10.8300
(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	6	12	0.0000
(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	SYRUP (SUGAR FREE (120ML, BOTTLE	1	1	6.5000
(ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) ENTERIC COATED TABLETS	ENTERIC COATED TABLETS (14S, BLISTER PACK)	7	7	0.0000