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: 10-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1984-3829310-6
Card Holder's Name: GOPI VELLAICHAMY VELLAICHAMY Age:40Y - 8M - 9D Sex:Male
Card Holder's Tel No: Mobile No: 0555064241
Ins Card No: I019-010-118489395-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36 B.P.140 Pulse. 96
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: R21 - Rash and other nonspecific skin eruption, R50.9 - Fever, unspecified, M25.59 - Pain in other specified joint

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

85027, COMPLETE CBC AUTOMATED , Lab,86430, RHEUMATOID FACTOR TEST QUAL , Lab,0005-149902-1021, CLOFEN , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
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 10-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CELECOXIB : 200 MG) CAPSULES	CAPSULES (30S, BLISTER PACK)	5	5	0.0000
(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	3	3	0.0000
(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	3	6	0.0000