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

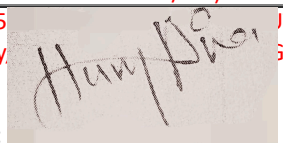
Medical Expenses Claim form

Date: 15-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1990-5297595-2
Card Holder's Name: IBRAHIM HAMDY MOHAMED BASSYOUNI Age: 35Y - 1M - 14D Sex: Male
Card Holder's Tel No: Mobile No: 0529655990
Ins Card No: I019-010-121824955-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No:_____ Nationality: Egyptian

Clinical Details: Temp37 B.P.132 Pulse. 82
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up visit
Diagnosis: J03.01 - Acute recurrent streptococcal tonsillitis, R50.9 - Fever, unspecified, R05 - Cough, R52 - Pain, unspecified

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

9, Consultation Gp , General Consultation,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,85 149902-1021, CLOFEN , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay



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

Doctor's Name: Humaira 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 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 15-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14	0.0000
(PANTOPRAZOLE (AS SODIUM) : 40 MG) GASTRO-RESISTANT TABLETS	GASTRO-RESISTANT TABLETS (30S, BLISTER PACK)	7	14	0.0000
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	5	1	0.0000
(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	TABLETS (24S, BLISTER PACK)	7	21	0.0000
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10	0.0000
(DICLOFENAC POTASSIUM : 50 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK	3	6	0.0000