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

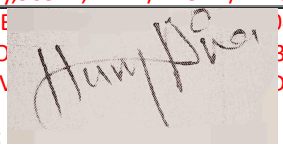
Date: 16-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-8210760-2
Card Holder's Name: SIDHARTH RAVEENDRAN EDONIMMAL RAVEENDRAN Age: 26Y - 2M - 1D Sex: Male
Card Holder's Tel No: Mobile No: 0553049284
Ins Card No: I019-010-118678031-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp37 B.P.124 Pulse. 58
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J03.90 - Acute tonsillitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough, R52 - Pain, unspecified

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,0195-107704-0802, CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0102-111908-1001, SODIUM CHLORIDE E[illegible] MG/2ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, AIRWAY INHALATIO[illegible] THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96374, THER/PROPH/DIAG INJ IV[illegible] Co.Pay,9, Consultation Gp , General Consultation

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 16-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
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10	0.0000
(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	TABLETS (24S, BLISTER PACK)	5	15	0.0000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.0000
(PANTOPRAZOLE (AS SODIUM : 20 MG ENTERIC COATED TABLETS	ENTERIC COATED TABLETS (30S, BLISTER	7	14	1.5200