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: 19-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-2494008-5
Card Holder's Name: ni luh era novita Age: 25Y - 5M - 8D Sex: Female
Card Holder's Tel No: Mobile No: 0562159853
Ins Card No: I005-010-120488194-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Indonesian

Clinical Details: Temp36.4 B.P.116 Pulse. 86
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J01.41 - Acute recurrent pansinusitis, J45.991 - Cough variant asthma, R51.9 - Headache, unspecified, R50.9 - Fever, unspecified, E86.0 - Dehydration

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

85027, COMPLETE CBC AUTOMATED , Lab,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10 INFUSION , Pharmacy,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,012 PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , Ge TO

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 19-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)