

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: 24-Feb-2025

Emirates: 784-2002-5908779-7 Clinic Name: CITICARE MEDICAL CENTER LLC Card Holder's Name: WAI YAN PHYOE Age: 22Y - 8M - 12D Sex: Male

Card Holder's Tel No: Mobile No: 507890723

Ins Card No: 1005-010-121769263-01 Valid Upto: 30/9/2025

Company **FMC Standard Employee**

_Nationality:<mark>Myanmarese</mark> Name: Network No.



Clinical Details:	Temp <mark>37</mark>	B.P. <mark>122</mark>	Pulse. <mark>93</mark>		
Signs & Symptoms:					
Date of Onset Illness:		\bigcirc Emergency \bigcirc W	/ork related ○ New visit ○ Follow up visit		
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R52 - Pain, unspecified					

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

0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE: 1 G) POWDER FOR INJECTION, Pharmacy,0102-152902-1001, LACTATED RINGERS INJECTION USP, Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR, Co.Pay,0005-149902-1021, CLOFEN, Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM

Co.Pay,96360, HYDRATION IV INFUSION INIT, Co.Pay,96374, THER/PROPH/DIAG IN Consultation,85027, COMPLETE CBC AUTOMATED, Lab

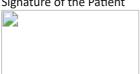
Doctor's Name: Enomen Goodluck signature with seal: Dr. Enomen Goodluck Ekata **General Practitioner** DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.

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 abovementioned 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, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 24-Feb-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(SODIUM CITRATE : 57 MG/5ML (AMMONIUM CHLORIDE : 131.5 MG/5 ML (MENTHOL : 1.1 MG/5 ML (DIPHENHYDRAMINE HCL : 13.5 MG/5ML SYRUP	SYRUP (120ML, BOTTLE	5	15	0.000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.000
(AMOXICILLIN: 500 MG) (CLAVULANIC ACID: 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.000
(CHLORPHENIRAMINE MALEATE : 2 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG TABLETS	TABLETS (24S, BLISTER PACK	5	15	0.540