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: 26-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1984-2803249-8
Card Holder's Name: SALMAN MUKHTYAR Age: 40Y - 11M - 12D Sex: Male
Card Holder's Tel No: Mobile No: 0566867438
Ins Card No: I005-010-115889321-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36 B.P.110 Pulse. 86
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: R21 - Rash and other nonspecific skin eruption, R52 - Pain, unspecified, L03.818 - Cellulitis of other sites

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

0005-111805-1021, (CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION , Pharmacy,85025, COMPLETE CE
DIFF WBC , Lab,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,51.02, Non-Surgical Cleansing With Surgical Dressing Between 1
100 Sq Centimeters And 48 Sq Inches / 300 Sq Centimeters , General Consultation,0195-107704-0802, CEFTRIAXONE-TABUK II
Pharmacy,9, Consultation Gp , General Consultation,0125-122107-1022, DEXAMET
MG/ML) SOLUTION FOR INJECTION , Pharmacy

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah I
General Practit
DHA: 98486553
CITICARE MEDICA
DUBAI - U.A

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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 26-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quanti
(NEPAFENAC : 0.1% EYE DROPS	EYE DROPS (5ML, PLASTIC DROPPER BOTTLE	3	6
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	5	5
(CLAVULANIC ACID : 125 MG (AMOXICILLIN : 875 MG TABLETS	TABLETS (14S, STRIP	3	3

Medicine	Dose	Duration	Quanti
(BETAMETHASONE : 0.10% (FUSIDIC ACID : 2% CREAM	CREAM (15G, COLLAPSIBLE TUBE	5	10