

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: 27-Feb-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1990-6668021-8
Card Holder's Name: PRAPATSORN KERDMARK Age: 34Y - 5M - 21D Sex: Female

Card Holder's Tel No: Mobile No: 0506965824

Ins Card No: 1005-010-117539996-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: Nationality: Tha

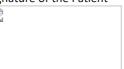


Company Name: FMC Stand	dard Network Employee N	No: Nationality: Thai	
Clinical Details: Signs & Symptoms: risk of fa	Temp <mark>36</mark>	B.P.106	Pulse. 99
Date of Onset Illness:		\bigcirc Emergency \bigcirc Work relat	ted $ igcirc$ New visit $ igcirc$ Follow up visit
Diagnosis: R21 - Rash and o	ther nonspecific skin erup	otion, R52 - Pain, unspecified, R51.9 - Headach	e, unspecified
Management plan (Servic	es inside the clinic includi	ng injections and investigations)	
9, Consultation Gp , Genera	l Consultation,0135-1499	02-0511, (DICLOFENAC SODIUM: 75 MG/3ML) INJECTION , Pharmacy,2190-106618-
1001, PARAFUSIV I.V. 10MG	/ML-(PARACETAMOL : 10	MG/ML) SOLUTION FOR INFUSION, Pharmacy	,,0125-122107-1022, DEXAMETHASONE
SODIUM PHOSPHATE-(DEXA	AMETHASONE : 4 MG/ML)) SOLUTION FOR INJECTION, Pharmacy,96372,	, THER/PROPH/DIAG INJ SC/IM ,
Co.Pay,96375, TX/PRO/DX I Doctor's Name: DR Amaiza		signature with seal:	Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E
Doctor s Hamer Bit Amaze	311	Signature With Sean	27 to to 10 min
Diagnostic Procedures refer	rred 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 27-Feb-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(PREDNISOLONE : 5 MG TABLETS	TABLETS (20S, BLISTER PACK	3	3	0.4300
(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (32S, BLISTER)	5	10	0.0000
(MOMETASONE FUROATE : 50 MCG) NASAL SPRAY PUMP	NASAL SPRAY PUMP (120 DOSE, METERED DOSE INHALER)	3	1	0.0000