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: 28-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-8210760-2
Card Holder's Name: SIDHARTH RAVEENDRAN EDONIMMAL RAVEENDRAN Age: 26Y - 2M - 13D 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: Temp 36.4 B.P. 110 Pulse. 68
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: R11.2 - Nausea with vomiting, unspecified, R19.7 - Diarrhea, unspecified, R10.9 - Unspecified abdominal pain

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

96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy,0005-136504-1021, SCOPINAL , Pharmacy,0233-116604-1002, (METRONIDAZOLE : 500 MG) SOLUTION FOR INFUSION , Pharmacy,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A , Pharmacy,9, Consultation Gp , General Consultation,96361, HYDRATE IV INFUSION

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 28-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(HYOSCINE : 10 MG TABLETS	TABLETS (500S, BLISTER PACK	5	10	0.1300
(DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000
(METRONIDAZOLE : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK	3	6	1.1000
(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (28.5G X 10, SACHET)	3	6	0.0000