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

WE TAKE CARE OF YOU

Medical Expenses Claim form

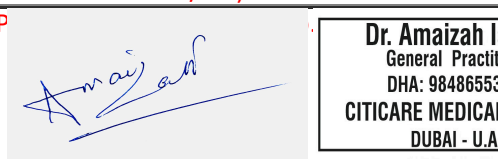
Date: 03-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1989-0281983-2
Card Holder's Name: bhupendra kumar Age: 35Y - 8M - 3D Sex: Male
Card Holder's Tel No: Mobile No: 0543971634
Ins Card No: I005-010-119899044-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Nepalese

Clinical Details: Temp36 B.P.50 Pulse. 74
Signs & Symptoms: Risk of Fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: R52 - Pain, unspecified, R50.9 - Fever, unspecified, R53.1 - Weakness

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

85027, COMPLETE CBC AUTOMATED , Lab,0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,96360, HYDRAT
INFUSION INIT , Co.Pay,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION
Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECT
Pharmacy,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,96372, THER/P
General Consultation,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay

Doctor's Name: DR Amaizah signature with seal:



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 03-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)