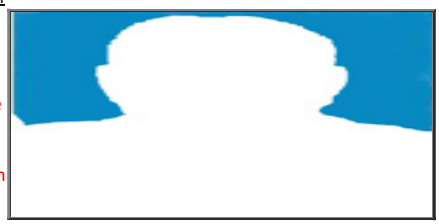
ANNEXURE V

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: 03-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-2758002-0
Card Holder's Name: TEYASHA PAL NARAYAN PAL Age: 26Y - 9M - 8D Sex: Female
Card Holder's Tel No: Mobile No: 0545462485
Ins Card No: I019-010-119814474-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36 B.P.117 Pulse. 86
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: K29.00 - Acute gastritis without bleeding, R11.2 - Nausea with vomiting, unspecified, E86.0 - Dehydration, R52 - Pain, unspecified, R19.7 - Diarrhea, unspecified

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

0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy,85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0131-116601-1001, (METRONIDAZOLE : 500 MG/100ML) SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96 122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG 174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION , Pha ;9, Consultation Gp , General Consultation,96375, TX/PRO/DX INJ NEW DRUG ADDON

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
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 03-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CALCIUM : 400 MG) (VITAMIN D3 : 200 IU) (MAGNESIUM : 100 MG) (ZINC : 4 MG) TABLETS	TABLETS (30S, BOX)	30	30	0.0000
(HYOSCINE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (1000S, BLISTER PACK	2	2	0.2300
(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (28.5G X 10, SACHET)	3	1	0.0000
(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	TABLETS (20S, BLISTER PACK)	3	6	0.0000