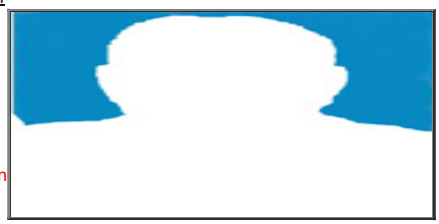
ANNEXURE V

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: 07-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2006-5743947-5
Card Holder's Name: ALYA ZAHIRA Age: 18Y - 5M - 23D Sex: Female
Card Holder's Tel No: Mobile No: 0553544604
Ins Card No: I005-010-121780493-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Indonesian

Clinical Details: Temp37.2 B.P.116 Pulse. 88
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J03.90 - Acute tonsillitis, unspecified, R50.9 - Fever, unspecified, R52 - Pain, unspecified, R11.2 - Nausea with vomiting, unspecified, K29.00 - Acute gastritis without bleeding, E86.0 - Dehydration

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,0125-122107-1022 (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96374, THEI p , General Consultation,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay

Doctor's Name: AISHA signature with seal:

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
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 07-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMOXICILLIN : 250 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	7	14	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES	DELAYED RELEASE CAPSULES (30S, CONTAINER	7	14	1.9700
(DOMPERIDONE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK	3	6	0.4700
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	15	0.0000
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	3	6	0.0000