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

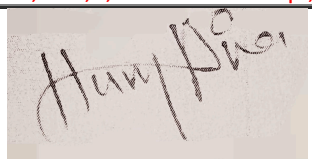
Date: 07-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-7425254-3
Card Holder's Name: VARAPRASAD MARAKANTI MARAKANTI PEDDA SAILU Age: 24Y - 6M - 24D Sex: Male
Card Holder's Tel No: Mobile No: 971563093585
Ins Card No: I019-010-118001760-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 36.5 B.P. 112 Pulse. 84
Signs & Symptoms:
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follov
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R09.81 - Nasal congestion, J30.9 - Allergic rhinit unspecified

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

0005-111805-1021, CHLOROHISTOL 10MG , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,(1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0102-1529 LACTATED RINGERS INJECTION USP , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,9, Consultation Gp , General Consult THER/PROPH/DIAG INJ IV PUSH , Co.Pay

Doctor's Name: Humaira 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 07-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quanti
(SODIUM CITRATE : 57 MG/5ML (AMMONIUM CHLORIDE : 131.5 MG/5 ML (MENTHOL : 1.1 MG/5 ML (DIPHENHYDRAMINE HCL : 13.5 MG/5ML SYRUP	SYRUP (120ML, BOTTLE	5	1
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5
(AZITHROMYCIN : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER	5	5

Medicine	Dose	Duration	Quanti
(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	TABLETS (24S, BLISTER PACK)	5	15