

ANNEXURE V

F M C NETV

P. O. BOX: 50430, DUBAI, Tel – Email – approval@fmchealthcare.ae

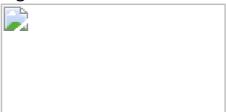
Medical Expenses Claim for

		,	Medical Expenses claim for
Date: 11-Mar-2	2025		
Clinic Name:	CITICARE MEDICA	L CENTER LLC Emira	ites: 784-1997-3794462-1
Card Holder's	HASARU UDAY	A KUMARA KULARATHN	A Age: 27Y - 9M - Sex:Ma
Name:	MADDUMAGE		1D
Card Holder's Tel No:		Mobile No:	0524552267
Ins Card No:	1019-010-1190)56811-01 V	'alid Upto: 7/6/2025
Company	FMC Standard	Employee	Nationality:
Name:	Network	No:	Nationality: Lankan
Clinical Details	:	Temp <mark>36.8</mark>	B.P. 127
Signs & Sympt	oms:		
Date of Onset	Illness:		○ Emergeno
Diagnosis: <mark>Z87</mark>	.440 - Personal his	story of urinary (tract) in	nfections, R52 - Pain, unspe
Managemen	t plan (Services in	side the clinic including	injections and investigation
0195-107704-0	0801, CEFTRIAXON	NE-TABUK IV , Pharmacy	,0102-152902-1001, LACTA ⁻
1021, CLOFEN	, Pharmacy, 96365	, IV INFUSION THERAPY	//PROPHYLAXIS /DX 1ST TO
, Co.Pay			
Doctor's Nam	ne: Humaira		signature with seal:
Diagnostic Pro	cedures referred o	outside:	

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical sementioned examination/Investigation/therapy is given to me by the doctor. I hereby person who has provided medical services to me to furnish any and all information medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 11-Mar-2025



Pharmaceuticals (to be filled by treating doctor only)