ANNEXURE V

F M C NETW

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

Medical Expenses Claim for

Date: 11-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-3794462-1
Card Holder's Name: HASARU UDAYA KUMARA KULARATHNA MADDUMAGE Age: 27Y - 9M - 1D Sex: Ma
Card Holder's Tel No: Mobile No: 0524552267
Ins Card No: I019-010-119056811-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 36.8 B.P. 127
Signs & Symptoms:
Date of Onset Illness :
○ Emergenc
Diagnosis: Z87.440 - Personal history of urinary (tract) infections, R52 - Pain, unspec

Management plan (Services inside the clinic including injections and investigation

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0102-152902-1001, LACTAT
1021, CLOFEN , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO
, 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 se
mentioned examination/Investigation/therapy is given to me by the doctor. I hereb
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)