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

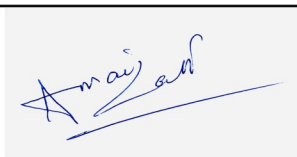
Date: 18-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-9391200-8
Card Holder's Name: DEEPAK TAMANG Age: 27Y - 0M - 22D Sex: Male
Card Holder's Tel No: Mobile No: 0588190846
Ins Card No: I019-010-118433315-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Nepalese

Clinical Details: Temp 36.8 B.P. 130 Pulse. 78
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: R21 - Rash and other nonspecific skin eruption

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Phar
THER/PROPH/DIAG INJ SC/IM , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,9, Consultation
Consultation

Doctor's Name: DR Amaizah 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 a
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, medical
medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 18-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantit
(FLUCONAZOLE : 150 MG CAPSULES (HARD GELATIN	CAPSULES (HARD GELATIN (1S, BLISTER PACK	1	1
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5

Medicine	Dose	Duration	Quantit
(TERBINAFINE (AS HCL : 1% CREAM	CREAM (15G, TUBE	30	1