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

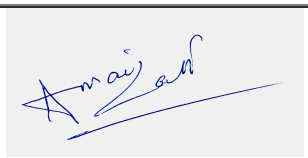
Date: 18-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-2734324-9
Card Holder's Name: DONA SAJANI GAYARA KANDAWALA Age: 28Y - 10M - 9D Sex: Female
Card Holder's Tel No: Mobile No: 971502775824
Ins Card No: I019-010-120845303-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 36.8 B.P. 134 Pulse. 82
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: K29.00 - Acute gastritis without bleeding

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

0005-174202-0781, RISEK 40MG , Pharmacy,0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,96360, HYDRA INFUSION INIT , Co.Pay,0005-150403-1021, (METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: DR Amaizah signature with seal:



Dr. Amaizah Isl
General Practitio
DHA: 98486553-
CITICARE MEDICAL
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 a mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy c 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)