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

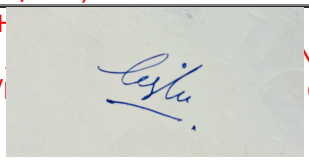
Medical Expenses Claim form

Date: 20-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2001-8832300-8
Card Holder's Name: MOHAMMED INDISHAM SALAHUDEEN MOHAMMED NALEEM Age: 24Y - 2M - 15D Sex: Male
Card Holder's Tel No: Mobile No: 0557719405
Ins Card No: I005-010-118947924-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 37.7 B.P. 120 Pulse. 96
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough, J30.9 - Allergic rhinitis, unspecified, E8 Dehydration, R52 - Pain, unspecified

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SO FOR INFUSION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUT INJECTION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmac 107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0102-100104-1001, SODIUM CH THER/PROPH/DIAG INJ SC/IM , Co.Pay,96375, TX/PRO/DX INJ NEW DRUG ADDON Co.Pay,9.01, Free Follow-Up Consultation Gp , General Consultation,96374, THER/



Dr. Aisha Um
Physician- General Pra
DHA- 40131439-0
CITICARE MEDICAL
DUBAI - U.A.E

Doctor's Name: AISHA 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 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 20-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quanti
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER)	5	10
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	15
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5

Medicine	Dose	Duration	Quanti
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	3	6