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: 784-1991-8486410-8
Card Holder's Name: RUPEI PURI Age: 34Y - 1M - 24D Sex: Female
Card Holder's Tel No: Mobile No: 0558843982
Ins Card No: I005-010-116984878-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Nepalese

Clinical Details: Temp36.8 B.P.110 Pulse. 82
Signs & Symptoms: risk of fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J03.90 - Acute tonsillitis, unspecified, J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough, E86.0 - Dehydration

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

85027, COMPLETE CBC AUTOMATED , Lab,86060, ANTISTREPTOLYSIN O TITER , Lab,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0046-149902-0511, (DICLOFENAC SODIUM : 75 MG/3ML) INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0102-152902-1001, LACTATED RINGERS INJECTION USP , Pharmacy,963[illegible] AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT , Pharr[illegible] Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,9637[illegible] Consultation Gp , General Consultation

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
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 above-mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or 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	Quantity	Price
(CETIRIZINE HCL : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK	7	7	0.9000
(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	7	14	0.0000
(PREDNISOLONE : 20 MG TABLETS	TABLETS (40S, BLISTER	3	3	1.4300
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	5	1	0.0000
(DICLOFENAC SODIUM : 100 MG) COATED TABLETS	COATED TABLETS (30S, BLISTER PACK)	3	3	0.0000