

ANNEXURE V

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

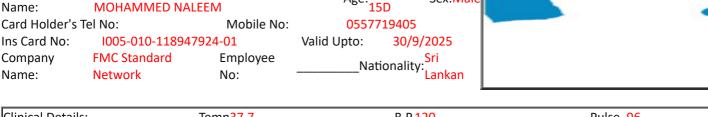
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2001-8832300-8

Card Holder's MOHAMMED INDISHAM SALAHUDEEN Sex:Male

Card Holder's Tel No: Mobile No: 0557719405

1005-010-118947924-01 Valid Upto: Ins Card No: 30/9/2025 Company **FMC Standard Employee**

Name: Network No:



Clinical Details: Temp37.7 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, E

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) SC 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 CF THER/PROPH/DIAG INJ SC/IM , Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.P. Consultation,96374, THER/PROPH/DIAG INJ IV PUSH, Co.Pay,96374, THER/PROPH ADD-ON, Co.Pav,96375, TX/PRO/DX INJ NEW DRUG ADDON, Co.Pav,0102-100104 PROCTOR'S, Name:10分析4-0801, CEFTRIAXONE-TABUK IV, Pharmigv3时的5-Y性与96月1

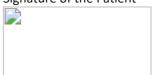
Dr. Aisha Un Physician- General Pra DHA- 40131439-0 CITICARE MEDICAL DUBAI - U.A.E

SOLUTION FOR INJECTION, Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE: 4 MG/ Diagniustic Procedures referred outside 190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION F INFUSION, Pharmacy,85025, COMPLETE CBC W/AUTO DIFF WBC, Lab,9.01, Free Follow-Up Consultation Gp, General Consulta IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR, Co.Pay

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)

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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