

ANNEXURE V

FMCNETWORK 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: 21-Mar-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-8482131-7 Card Holder's Name: KHARAK SINGH KISHAN SINGH Age: 26Y - 8M - 6D Sex: Male

Card Holder's Name: KHARAK SINGH KISHAN SINGH Age: 26Y - 8M - 6D Sex: Male Card Holder's Tel No: Mobile No: 0569469783

Ins Card No: 1005-010-119076401-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: ________ Nationality: Indian



Clinical Details:	Temp <mark>36.8</mark>	B.P.120	Pulse. 88
Signs & Symptoms: RISK FOR FAL <mark>l</mark>	L		
Date of Onset Illness :		○ Emergency ○ Work related	O New visit O Follow up visit
Diagnosis: J <mark>03.90 - Acute tonsilliti</mark>	s, unspecified, R50.9 - Fever, unsp	ecified, J02.9 - Acute pharyngitis, ur	nspecified, J45.991 - Cough variant
asthma			

1anagement							

85027, COMPLETE CBC AUTOMATED , Lab,86060, ANTISTREPTOLYSIN O TITER , Lab,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,94640, AIRWAY INHALATION TREATMENT , Co.Pay,0188-135906-2441, PULMICORT ,

Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM, Co.Pay, 9, Consultation Gp, Gene

signature with seal:

Dr. Amaizah Ishtiaq General Practitioner Dha: 98486553-001 Citicare Medical Center Dubal - U.A.E

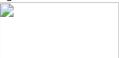
Diagnostic Procedures referred outside:

Doctor's Name: DR Amaizah

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 21-Mar-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	5	10	0.0000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	3	1	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (48S, BLISTER PACK)	3	6	0.0000