



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: 04-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-2000-3181648-9

Card Holder's Name: THARAK DILHARA

Age: 30Y - 0M - 18D Sex: Male

Card Holder's Tel No:

Mobile No:

0529618685

Ins Card No: I005-010-122181987-01

Valid Upto:

30/9/2025

Company Name: FMC Standard Network Employee No: Nationality: Egyptian



Clinical Details:

Temp 37.8

B.P. 130

Pulse: 78

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis: R21 - Rash and other nonspecific skin eruption, R50.9 - Fever, unspecified, R52 - Pain, unspecified, E86.0 - Dehydration, B01.9 - Varicella without complication

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

0005-149902-1021, CLOFEN , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 85027, COMPLETE CBC AUTOMATED , Lab, 0384-207801-1002, LACTATED RINGER'S & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION (500ML, BOTTLE) , Pharmacy, 96361, HYDRATE General Consultation, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HI Co.Pay, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Doctor's Name: DR Amaizah

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 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 04-Apr-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)	5	5	0.0000
(CALAMINE : 15 G/100ML) (ZINC OXIDE : 5 G/100ML) (PHENOL : 0.5 G/100ML) (BENTONITE : 3 G/100ML) LOTION	LOTION (1S, PLASTIC BOTTLE)	5	1	0.0000
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000