

## 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: 1005-010-122181987-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: Nationality: Egyptian



Clinical Details:	Temp <mark>37.8</mark>	B.P.130	Pulse. 78				
Signs & Symptoms: RISK FOR FALL							
Date of Onset Illness:		○ Emergency ○ Wo	ork related $ igcirc$ New visit $ igcirc$ 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 comp	olication						

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 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

Doctor's Name: DR Amaizah signature with seal:

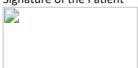
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Dr. Amaizah Ishtiaq General Practitioner Dha: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E

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)

The made and the sea med of the anning about 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			