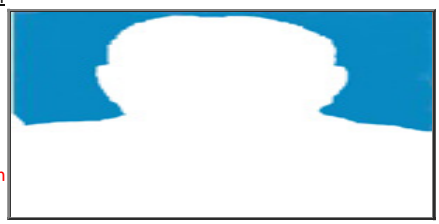
ANNEXURE V

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: 05-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2002-7613014-1
Card Holder's Name: PUJA ROY Age: 22Y - 10M - 24D Sex: Female
Card Holder's Tel No: Mobile No: 05445482315
Ins Card No: I005-010-122031303-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J03.90 - Acute tonsillitis, unspecified, R50.9 - Fever, unspecified

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

0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION , Pharmacy,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,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 PHOSPHAT Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,96365, IV INFUSION THERA

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 05-Apr-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
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 325 MG) CAPLETS	CAPLETS (24S, BOX)	3	6	0.0000