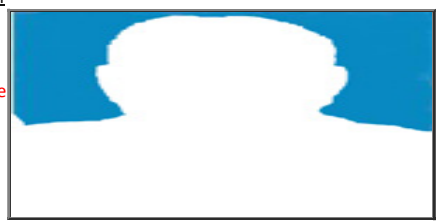
ANNEXURE V

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: 784-1984-8519140-1
Card Holder's Name: CHAMITHDESHITHA THANTHIRIGE Age: 40Y - 3M - 28D Sex: Male
Card Holder's Tel No: Mobile No: 0567739250
Ins Card No: I019-010-120763954-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 38.9 B.P. 120 Pulse. 68
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J03.90 - Acute tonsillitis, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified

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

0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXI[illegible]al Consultation

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)