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

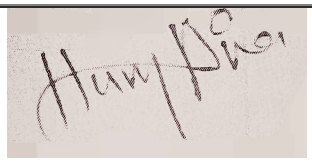
Date: 09-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2004-2015488-0
Card Holder's Name: MUHAMAD TAUPIK Age: 21Y - 2M - 5D Sex: Male
Card Holder's Tel No: Mobile No: 0504306289
Ins Card No: I019-010-121177973-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Indonesian

Clinical Details: Temp36.8 B.P.120 Pulse. 68
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R05 - Cough, R07.0 - Pain in throat, R09.81 - Nasal congestion

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

9, Consultation Gp , General Consultation,0188-135906-2441, PULMICORT , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,S
AIRWAY INHALATION TREATMENT , Co.Pay

Doctor's Name: Humaira 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 abo
mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or a
person who has provided medical services to me to furnish any and all information with regard to any medical history, medical cor
medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 09-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	10
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10

Medicine	Dose	Duration	Quantity
(PARACETAMOL : 600 MG) (PHENYLEPHRINE HCL : 10 MG) ORAL POWDER	ORAL POWDER (10S, SACHET)	5	15