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: 12-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1990-5538911-0
Card Holder's Name: PYONE KAY THI NWE Age: 34Y - 11M - 8D Sex: Female
Card Holder's Tel No: Mobile No: 0569035768
Ins Card No: I019-010-120439520-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Myanmarese

Clinical Details: Temp37.8 B.P.110 Pulse. 92
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J03.90 - Acute tonsillitis, unspecified, R52 - Pain, unspecified, R50.9 - Fever, unspecified, R21 - Rash and other nonspecific skin eruption, K29.00 - Acute gastritis without bleeding

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

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,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,850 THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation,9 IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , 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 12-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
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (24S, BLISTER PACK)	3	6	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) ENTERIC COATED TABLETS	ENTERIC COATED TABLETS (28S, BLISTER PACK)	5	5	0.0000