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

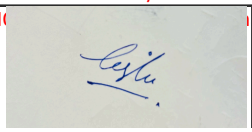
Date: 21-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-2656768-4
Card Holder's Name: AHMAD JAMAL QAISAR KHALIL Age: 31Y - 10M - 15D Sex: Male
Card Holder's Tel No: Mobile No: 0522795599
Ins Card No: I019-010-118620467-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Pakistani

Clinical Details: Temp 36.3 B.P. 130 Pulse. 70
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: A05.9 - Bacterial foodborne intoxication, unspecified, R19.7 - Diarrhea, unspecified, R11.2 - Nausea with vomiting, unspecified, E86.0 - Dehydration, R10.9 - Unspecified abdominal pain

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-136504-1021, SCOPINAL , Pharmacy,0005-150403-1021, PREMOSAN , Pharmacy,0233-116604-1002, (METRONIDAZOLE : 500 MG) SOLUTION FOR INFUSION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTI
General Consultation

Doctor's Name: AISHA signature with seal:



Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
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 21-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(HYOSCINE : 10 MG) TABLETS	TABLETS (500S, BLISTER PACK)	5	10	0.1300
(LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (6S, BLISTER PACK)	5	10	0.0000
(DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000
(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	POWDER FOR SOLUTION (10 X 4.4 G, SACHET)	3	6	0.0000