

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: 25-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1987-8304272-8
Card Holder's Name: Jennelyn Deza Arellano Age: 37Y - 9M - 10D Sex: Female

Card Holder's Tel No: Mobile No: 0526800421
Ins Card No: 1005-010-116122173-01 Valid Upto: 30/9/2025

Company FMC Standard Employee Name: Network No:



Clinical Details: Signs & Symptoms:	Temp <mark>37</mark>	B.P.130	Pulse. 84		
Date of Onset Illness:		○ Emergency ○ W	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit runspecified, J30.9 - Allergic rhinitis, unspecified, R52 - Pain, unspecified,		
Diagnosis: J02.9 - Acute R05 - Cough, E86.0 - Deh	, , , ,	- Fever, unspecified, J30.9 - Allergic	rhinitis, unspecified, R52 - Pain, unspecified,		

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0195-

signature with seal:

107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0102-100104-1001, SODIUM CHTHER/PROPH/DIAG INJ SC/IM , Co.Pay,96361, HYDRATE IV INFUSION ADD-ON , Co. TO 1 HR , Co.Pay,9, Consultation Gp , General Consultation,96374, THER/PROPH/D



Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E

LST

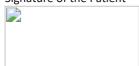
Diagnostic Procedures referred outside:

Doctor's Name: AISHA

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 25-Apr-2025



Pharmaceuticals (to be filled by treating doctor only)

That made actions (to be miles by a catally addition only)							
Medicine	Dose	Duration	Quantity	Price			
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	10	0.0000			
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	15	0.0000			
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	3	6	0.0000			
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10	0.0000			
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.0000			