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: I005-010-116122173-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Philippine

Clinical Details: Temp37 B.P.130 Pulse. 84
Signs & Symptoms:
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up visit
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, J30.9 - Allergic rhinitis, unspecified, R52 - Pain, unspecified, R05 - Cough, E86.0 - Dehydration

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,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0439-152905-1001, LACTATED F[illegible] THER/PROPH/DIAG INJ SC/IM , Co.Pay,96361, HYDRATE IV INFUSION ADD-ON , Co.[illegible] 1ST TO 1 HR , Co.Pay,9, Consultation Gp , General Consultation,96374, THER/PROPH/D[illegible]

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 25-Apr-2025

Pharmaceuticals (to be filled by treating doctor 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