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

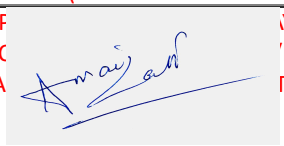
Medical Expenses Claim form

Date: 26-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-2521328-5
Card Holder's Name: NEETA HARIBHAI KHIMSURIYA HARIBHAI ANANDBHAI KHIMSURIYA Age: 26Y - 7M - 8D Sex:Female
Card Holder's Tel No: Mobile No: 0568678104
Ins Card No: I005-010-121540611-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp37.6 B.P.120 Pulse. 84
Signs & Symptoms: risk of fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J03.90 - Acute tonsillitis, unspecified, J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R50.9 - Fever, unspecified, E86.0 - Dehydration

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

85027, COMPLETE CBC AUTOMATED , Lab,0195-107704-0801, CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0439-152905-1001, LACTATED RINGERS INJECTION USF , Co.Pay,9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC , Co.Pay,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,96365, IV INFUSION THERA



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, c medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 26-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CEFIXIME : 200 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (8S, BLISTER PACK)	7	14	0.0000
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	7	1	0.0000
(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (16S, BLISTER)	3	6	0.0000
(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	SPRAY SOLUTION (30ML, SPRAY BOTTLE)	5	1	0.0000