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: 01-May-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-1068137-1
Card Holder's Name: ARAVINDA RUMESH NETHSARA ATHTHANAYAKE ATHTHANAYAKE MUDIYANSELAGE Age: 26Y - 7M - 7D Sex: Male
Card Holder's Tel No: Mobile No: 0561023776
Ins Card No: I005-010-121925253-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 36.5 B.P. 106 Pulse. 78
Signs & Symptoms: Risk of fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up visit
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R09.81 - Nasal congestion, R19.7 - Diarrhea, unspecified, R50.9 - Fever, unspecified, R53.1 - Weakness, E86.0 - Dehydration, K29.00 - Acute gastritis without bleeding, R14.3 - Flatulence

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0442-116612-1001, (METRONIDAZOLE : 5 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION , Pharmacy,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ THER/PROPH/DIAG INJ SC/IM , Co.Pay,96361, HYDRATE IV INFUSION ADD-ON , Co. 1ST TO 1 HR , Co.Pay,9, Consultation Gp , 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 01-May-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)	3	6	0.0000
(LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (6S, BLISTER PACK)	5	10	0.0000
(SIMETHICONE : 42 MG) CHEWABLE TABLETS	CHEWABLE TABLETS (30S, BLISTER)	5	5	0.0000
(AZITHROMYCIN : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	10	0.0000
(CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET	CAPLET-TABLET (30S, BLISTER)	5	10	0.2500
(ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS	CHEWABLE TABLETS (40S, BLISTER PACK)	7	14	0.0000
(AZITHROMYCIN : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	10	0.0000