



ANNEXURE V

F M C NETWORK UAE

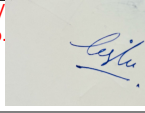
P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim form

Date: 01-May-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-1068137-1
Card Holder's ARAVINDA RUMESH NETHSARA ATHTHANAYAKE Age: 26Y - Sex: Male
Name: ATHTHANAYAKE MUDIYANSELAGE 7M - 7D
Card Holder's Tel No: Mobile No: 0561023776
Ins Card No: 1005-010-121925253-01 Valid Upto: 30/9/2025
Company FMC Standard Employee Nationality: Sri
Name: Network No: 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. TO 1 HR , Co.Pay,9, Consultation Gp , General Consultation	
Doctor's Name: AISHA	signature with seal:   1ST

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