

ANNEXURE V

FMCNETWORK 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: 12-May-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-6437490-8 Card Holder's Name: YOGESH ROHITASHWA KUMAR Age: 27Y - 10M - 27D Sex: Male

Card Holder's Tel No: Mobile No: 0566134498
Ins Card No: I019-010-116775830-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: ________Nationality: Indian



Clinical Details:	Temp <mark>36.4</mark>	B.P.132	Pulse. <mark>64</mark>	
Signs & Symptoms: RISK OF	FALL			
Date of Onset Illness :		○ Emergency ○ Work related ○ New visit ○ Follow up visit		
"	nsillitis, unspecified, J02.9 - A	Acute pharyngitis, unspecified, R50.9	- Fever, unspecified, R52 - Pain, unspecified,	
R06.2 - Wheezing	iisiiitis, urispecifieu, 102.3 - 7	Acute pharynghis, unspecified, 130.5	- Fever, unspecified, N32 - Fairi, unspecified	

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

0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9,

Consultation Gp , General Consultation

twai) and

Dr. Amaizah Ishtiaq General Practitioner Dha: 98486553-001 Citicare Medical Center Dubai - U.A.E

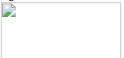
Doctor's Name: DR Amaizah signature with seal:

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

Signature of the Patient

Date 12-May-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	7	14	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	3	6	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (200S, BLISTER PACK)	3	3	0.2800
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	3	3	0.0000