



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: 15-May-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-1068137-1

Card Holder's ARAVINDA RUMESH NETHSARA ATHTHANAYAKE Age: 26Y - 7M Sex: Male

Name: ATHTHANAYAKE MUDIYANSELAGE - 21D

Card Holder's Tel No: Mobile No: 0561023776

Ins Card No: I005-010-121925253-01 Valid Upto: 30/9/2025

Company FMC Standard Employee Nationality: Sri

Name: Network No: Lankan



Clinical Details:	Temp 36.3	B.P. 100	Pulse. 70
Signs & Symptoms:	Risk of fall		
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis: J03.90 - Acute tonsillitis, unspecified, R05 - Cough, R50.9 - Fever, unspecified, R52 - Pain, unspecified, R06.2 - Wheezing, J30.9 - Allergic rhinitis, unspecified			

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION , Pharmacy, 94640, AIRWAY INHALATION TREATMENT , Co.Pay, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 96374, THER/PROPH/DIAG AUTOMATED , Lab, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR ,

Doctor's Name: DR Amaizah

signature with seal:

Dr. Amaizah Ishtiaq
 General Practitioner
 DHA: 98486553-001
 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 15-May-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, STRIP)	7	7	0.0000
(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	3	6	0.0000
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	1	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (200S, BLISTER PACK)	5	5	0.0000