

**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 formDate: **28-May-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1999-8651100-6**Card Holder's Name: **THARUSHI KAVINDAYA NETHMINI** Age: **26Y - 0M - 17D** Sex: **Female**Card Holder's Tel No: Mobile No: **0528470071**Ins Card No: **I005-010-121540583-01** Valid Upto: **30/9/2025**Company: **FMC Standard** Employee No: Nationality: **Sri Lankan**

Clinical Details: Temp **36** B.P. **112** Pulse: **86**
 Signs & Symptoms: **RISK OF FALL**
 Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
 Diagnosis: **J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough, R52 - Pain, unspecified, E86.0 - Dehydration, R09.81 - Nasal congestion**

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.Pay,96374, THER/PROPH/DIAG IN 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 **28-May-2025**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY	NASAL SPRAY (10ML, HDPE BOTTLE METERED DOSE SPRAY PUMP)	5	10	0.0000
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	10	0.0000
(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.4500
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.4300
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	5	10	0.0000