

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: 02-Jun-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-2652787-4 Card Holder's Name: PRIYA SAHU ARUN KUMAR SAHU Age: 27Y - 8M - 20DSex: Female

Card Holder's Tel No: Mobile No: +919630911307
Ins Card No: I005-010-118997977-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: ______Nationality: Indian



Clinical Details:	Temp <mark>38</mark>	B.P.116	Pulse. 111	
Signs & Symptoms:				
Date of Onset Illness :		\bigcirc Emergency \bigcirc Work related \bigcirc New visit \bigcirc Follow up visit		
Diagnosis: J02.9 - Acute phrhinitis	aryngitis, unspecified, R50.9	- Fever, unspecified, E86.0 - Dehydra	ation, R05 - Cough, J30.89 - Other allergic	

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,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0102-

100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,96372, THER/PROFINJ IV PUSH , Co.Pay,96376, TX/PRO/DX INJ SAME DRUG ADON , Co.Pay,96360, HY General Consultation

Leglu.

Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E

Diagnostic Procedures referred outside:

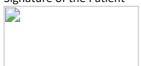
Doctor's Name: AISHA

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 with seal:

Signature of the Patient

Date 02-Jun-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
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	15	0.0000
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000
(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (120ML, BOTTLE)	5	10	0.0000
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.0000