

ANNEXURE V

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

0564911539

30/9/2025

Nationality: Nepalese

Date: 03-Jun-2025

Name:

Ins Card No:

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-2615750-0

Age: 30Y - 4M -Card Holder's LOKESH BHATTARAI KESHAB BAHADUR

KHATRI

Card Holder's Tel No: Mobile No:

1005-010-120916688-01 Valid Upto:

Company **FMC Standard Employee**

Name: Network No: Sex:Male

Clinical Details: Temp40 B.P.120 Pulse. 88 Signs & Symptoms: RISK FOR FALL Date of Onset Illness: ○ Emergency ○ Work related ○ New visit ○ Follow up visit Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, R52 - Pain, unspecified, R11.0 -Nausea, E86.0 - Dehydration

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

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,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,85027, COMPLETE CBC

AUTOMATED, Lab, 9.01, Free Follow-Up Consultation Gp, General Consultation, 96 TX/PRO/DX INJ NEW DRUG ADDON , Co.Pay,96361, HYDRATE IV INFUSION ADD-OI

Parlianflacine

Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBALU.A.F

Diagnostic Procedures referred outside:

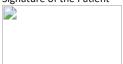
Doctor's Name: Dr.Farhan Iyas

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the abovementioned 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 03-Jun-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(PARACETAMOL : 600 MG) (PHENYLEPHRINE HCL : 10 MG) ORAL POWDER	ORAL POWDER (10S, SACHET)	5	15	0.0000
(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	10	0.0000
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	5	1	0.0000
(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000