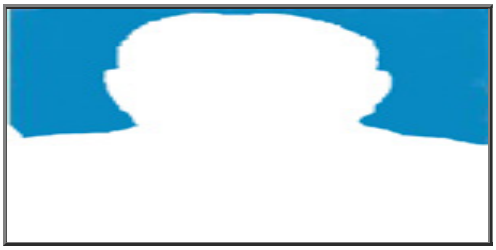
ANNEXURE V

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: 17-Jun-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1983-7280206-0
Card Holder's Name: PRAHLAD SINGH Age: 42Y - 2M - 11D Sex: Male
Card Holder's Tel No: Mobile No: 0506858637
Ins Card No: I005-010-119171364-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

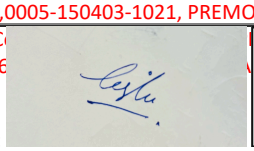


Clinical Details: Temp37.5 B.P.140 Pulse. 84
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: A05.9 - Bacterial foodborne intoxication, unspecified, R19.7 - Diarrhea, unspecified, K52.9 - Noninfective gastroenteritis and colitis, unspecified, R10.9 - Unspecified abdominal pain, E86.0 - Dehydration, R50.9 - Fever, unspecified, R11.0 - Nausea

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,0135-116611-1001, (METRONIDAZOLE : 0.5%) SOLUTION FOR INFUSION , Pharmacy,0005-136504-1021, SCOPINAL , Pharmacy,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy,9, Consultation Gp , General C Co.Pay,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,9636 TX/PRO/DX INJ NEW DRUG ADDON , Co.Pay

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 17-Jun-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	1	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	5	10	0.0000
(HYOSCINE : 10 MG) TABLETS	TABLETS (500S, BLISTER PACK)	5	10	0.1300
(METOCLOPRAMIDE : 10 MG) TABLETS	TABLETS (20S, BOX)	5	10	0.0000
(SODIUM CHLORIDE : 2.6 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) (DEXTROSE ANHYDROUS : 13.5 G) POWDER FOR SOLUTION	POWDER FOR SOLUTION (10X21.8G, SACHET)	3	6	0.0000