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

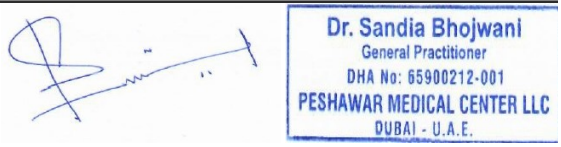
Date: 03-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1990-6668021-8
Card Holder's Name: PRAPATSORN KERDMARK Age: 34Y - 9M - 27D Sex: Female
Card Holder's Tel No: Mobile No: 0506965824
Ins Card No: I005-010-117539996-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Thai

Clinical Details: Temp36 B.P.111 Pulse. 94
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: R11.11 - Vomiting without nausea, R51.9 - Headache, unspecified, R53.1 - Weakness, M54.5 - Low back pain, R52 - Pain, unspecified

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

9, Consultation Gp , General Consultation,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,0005-150403-1021, PREMOSAN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,85027, COMPLETE CBC AUTOMATED , Lab,81005, URINALYSIS , Lab,2190-106618-1001, PARAFUS
I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy

Doctor's Name: SANDIA signature with seal:




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 ot person who has provided medical services to me to furnish any and all information with regard to any medical history, medical conditio medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 03-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quantity | Price |
|---|---|---|---|---|
| (IBUPROFEN : 400 MG) FILM COATED TABLETS | FILM COATED TABLETS (30S, BLISTER PACK) | 5 | 10 | 0.00 |
| (ETORICOXIB : 120 MG) TABLETS | TABLETS (10S, BLISTER) | 5 | 5 | 1.85 |