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

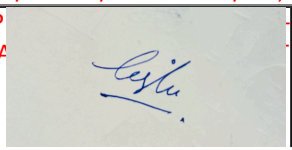
Date: 03-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1978-1026837-1
Card Holder's Name: JENNIFER MANATAD AMONTOS Age:46Y - 9M - 10D Sex:Female
Card Holder's Tel No: Mobile No: 0568670296
Ins Card No: I005-010-117303322-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Philippine

Clinical Details: Temp36.8 B.P.128 Pulse. 72
Signs & Symptoms: Risk of 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, E86.0 - Dehydration

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,96360, HYDRATION IV INFUSION INIT , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0439-152905-1001 LACTATED RINGERS INJECTION USP , Pharmacy,96374, THER/PROPH/DIAG INJ IV P (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, A Gp , General 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 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	Pric
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10	0.0(
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0(
(BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP	SYRUP (100ML, BOTTLE)	5	1	0.0(
(ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS	EFFERVESCENT TABLETS (10S, TUBE)	5	5	0.0(