

**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: 06-Jul-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-3794462-1

Card Holder's Name: HASARU UDAYA KUMARA KULARATHNA Age: 28Y - 0M - 26D Sex: Male

Card Holder's Tel No: Mobile No: 0553490496

Ins Card No: I019-010-119056811-02 Valid Upto: 7/6/2026

Company Name: FMC Standard Network Employee No: Nationality: Sri Lankan



Clinical Details:	Temp 37	B.P. 120	Pulse. 93
Signs & Symptoms:			
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis: J02.9 - Acute pharyngitis, unspecified, J30.89 - Other allergic rhinitis, R52 - Pain, unspecified, E86.0 - Dehydration, R50.9 - Fever, unspecified			

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, 96361, HYDRATE IV INFUSION ADD-ON , 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, 0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy, 9, Consultation Gp , General Cons /DX 1ST TO 1 HR , Co.Pay	
Doctor's Name: AISHA	signature with seal: 

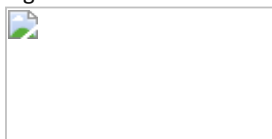
Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

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 06-Jul-2025

**Pharmaceuticals (to be filled by treating doctor only)**

Medicine	Dose	Duration	Quantity	Price
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	5	10	0.0000
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	10	0.0000
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	5	10	0.0000
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER PACK)	5	10	0.0000