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

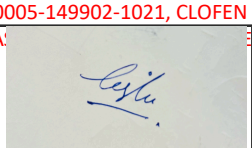
Date: 08-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1994-2810897-3
Card Holder's Name: DANUSHAKA MUTHUKUMARA ELLAPPERUMA ARACHCHIGE Age: 31Y - 4M - 4D Sex: Male
Card Holder's Tel No: Mobile No: 971589354096
Ins Card No: I019-010-120039269-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 38.4 B.P. 120 Pulse. 88
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R07.0 - Pain in throat, R52 - Pain, unspecified, 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,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0125-122107-1022, DEXAMETHA[illegible] THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation 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 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 08-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) (CHLORPHENIRAMINE MALEATE : 2 MG) TABLETS	TABLETS (24S, BLISTER)	5	10	0.0000
(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP)	5	10	0.0000
(POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION	MOUTHWASH-SOLUTION (250ML, PLASTIC BOTTLE)	3	6	0.0000