

**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 formDate: **16-Jul-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-2001-6735663-1**Card Holder's Name: **THIT THIT AUNG** Age: **24Y - 3M - 23D** Sex: **Female**Card Holder's Tel No: Mobile No: **0503656984**Ins Card No: **I005-010-121795239-01** Valid Upto: **30/9/2025**Company **FMC Standard** Employee _____ Nationality: **Myanmarese**
 Name: **Network** No: _____Clinical Details: Temp **37** B.P. **120** Pulse. **88**Signs & Symptoms: **RISK FOR FALL**Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ FollowDiagnosis: **R50.9 - Fever, unspecified, 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) S
 FOR INFUSION , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM
 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0439-152905-1001, LACTATED
 INJECTION USP , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay**

Doctor's Name: **AISHA**

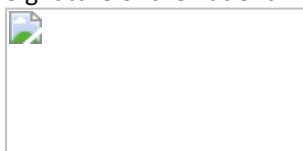
signature with seal:

Dr. Aisha U
 Physician- General P
 DHA- 40131439
 CITICARE MEDICA
 DUBAI - U.A

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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **16-Jul-2025**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	FILM COATED TABLETS (50S, BLISTER)	5	10