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: 21-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1986-9259365-4
Card Holder's Name: RIZWAN SHAUKAT SHAUKAT HAYAT Age: 38Y - 11M - 10D Sex: Male
Card Holder's Tel No: Mobile No: 0561822024
Ins Card No: I019-010-115402254-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Pakistani

Clinical Details: Temp 38.2 B.P. 130 Pulse. 102
Signs & Symptoms: risk for fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up visit
Diagnosis: E86.0 - Dehydration, K29.00 - Acute gastritis without bleeding, R11.2 - Nausea with vomiting, unspecified, R52 - Pain, unspecified, R50.9 - Fever, unspecified

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharmacy,0384-207801-1002, LACTATED RINGER'S & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION (500ML, BOTTLE) , Pharmacy,9, Consultation Gp , GE THER/PROPH/DIAG INJ SC/IM , Co.Pay,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,96374, THER/PROPH/D

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مركز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Doctor's Name: KEERTHANA 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 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 21-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (1000S, BLISTER PACK)	2	4	0.0000
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	2	8	0.0000
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	5	5	0.0000
(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (10S, SACHET)	5	15	2.0000