

<u>ANNEXURE V</u>

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

0509398753

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Date:	,,,_		1_ /	1115
Date.	~~ ,	u		-

Card Holder's Tel No:

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1984-8512574-8 Card Holder's Name: JAYA RATAN KAMBLE Age: 41Y - 2M - 10D Sex: Female

Mobile No:

Ins Card No: 1005-010-120106903-01 Valid Upto: 30/9/2025 Company Name: FMC Standard Network Employee No: ______Nationality: Indian



Clinical Details:	Temp <mark>36.8</mark>	B.P.100	Pulse. <mark>62</mark>	
Signs & Symptoms: RISK	OF FALL			
Date of Onset Illness:		\bigcirc Emergency \bigcirc Wo	rk related O New visit O Follow up visit	
-	-	ified, R30.0 - Dysuria, R50.9 - Fever, ui	nspecified, E86.0 - Dehydration, I95.9 -	
Hypotension, unspecifie	d, R52 - Pain, unspecified			

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,81005, URINALYSIS , 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, 96374, THER/PROPH/DIAG INJ IV PUSH, Co. Pay, 0005-149902-1021, CLOFEN-(DICLOFENAC SODIUM: 75

MG/3ML) SOLUTION FOR INJECTION, Pharmacy, 96372, THER/PROPH/DIAG INJ SC

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

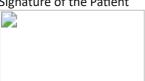
Doctor's Name: AISHA signature with seal:

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 abovementioned 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 22-Jul-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES	EFFERVESCENT GRANULES (4G X 10, SACHET)	5	10	0.0000
(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	5	10	0.0000