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: 23-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1981-1754627-9
Card Holder's Name: KANOKWAN KRAITEP Age: 43Y - 11M - 25D Sex: Female
Card Holder's Tel No: Mobile No: 0523261899
Ins Card No: I005-010-116365656-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Thai

Clinical Details: Temp36.5 B.P.110 Pulse. 68
Signs & Symptoms: Risk of Fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R05 - Cough, R07.0 - Pain in throat, R51.9 - Headache, unspecified, E86.0 - Dehydration, R12 - Heartburn

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

0005-107704-0801, TRIAXONE I.M.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,9, Consultation Gp , General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96360, HYDRATION IV [illegible]USION INIT , Co.Pay,963 IV PUSH , Co.Pay

Doctor's Name: KEERTHANA signature with seal:

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

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 23-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	5	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	5	5	0.0000
(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (100ML, GLASS BOTTLE)	5	75	0.0000
(PARACETAMOL : 500 MG) (CAFFEINE : 65 MG) FILM COATED TABLETS	FILM COATED TABLETS (72S, BLISTER)	3	6	0.0000
(POVIDONE IODINE : 1%) GARGLE	GARGLE (125ML, BOTTLE)	3	45	0.0000