

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:	24-J	lul-	20	25
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Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1988-1594872-8 Age: 37Y - 2M - 1D Sex: Female Card Holder's Name: MICHELLE SABALAN

Card Holder's Tel No: Mobile No: 0569132882 Ins Card No: 1005-010-119448945-01 Valid Upto: 30/9/2025

Company **FMC Standard Employee**

Nationality: Philippine Name: Network No:



Clinical Details:	Temp <mark>38.5</mark>	B.P.110	Pulse. 108
Signs & Symptoms: risk o	f fall		
Date of Onset Illness:		○ Emergency ○ Wo	ork related $ igcirc$ New visit $ igcirc$ Follo
Diagnosis: J03.90 - Acute	tonsillitis, unspecified, R52 - P	ain, unspecified, R51.9 - Headache, (unspecified, R05 - Cough, E86.0 -
K29.60 - Other gastritis w	vithout bleeding		

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,0125-12210 DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE: 4 MG/ML) SOLUTION FOR INJECTION, Pharmacy,0384-207801-LACTATED RINGER'S & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM (

N/A) (SODIUM LACTATE: N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION DOML, BOTTLE), Pharma CEFTRIAXONE-TABUK IV, Pharmacy,85027, COMPLETE CBC AUTOMATED, Lab,96365, IV INFUSION THERAPY HR, Co.Pay,96375, TX/PRO/DX INJ NEW DRUG ADDON, Co.Pay,9, Consultation Gp, General Consultation,963 ADD-ON, Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM, Co.Pay

رانی بادیبورایل ثارا Dr. Keerthana Rani Padip **General Practi** License No.: 37864 بتيكير الطبي ذم م CITICARE MEDICAL C

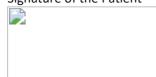
Doctor's Name: KEERTHANA signature with seal:

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 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, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 24-Jul-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	3	12
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	5	5

Medicine	Dose	Duration	Quan
(AMBROXOL : 30 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (100ML, GLASS BOTTLE)	5	75