



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-Jul-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1988-1594872-8

Card Holder's Name: MICHELLE SABALAN

Age: 37Y - 2M - 1D Sex: Female

Card Holder's Tel No:

Mobile No: 0569132882

Ins Card No: I005-010-119448945-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Philippine



Clinical Details:

Temp 38.5

B.P. 110

Pulse. 108

Signs & Symptoms: risk of fall

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: J03.90 - Acute tonsillitis, unspecified, R52 - Pain, unspecified, R51.9 - Headache, unspecified, R05 - Cough, E86.0 - C
K29.60 - Other gastritis without 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, 0125-1221C
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 C
N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION 100ML, BOTTLE) , Pharm
CEFTRIAZONE-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
Doctor's Name: KEERTHANA

signature with seal:

راني كيرثانا راني
Dr. Keerthana Rani Padipi
General Practitioner
License No.: 37864
بتيكير الطبي ذم م
CITICARE MEDICAL C

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 24-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

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