

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	ul-2	20	25
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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: 1005-010-119448945-01 Valid Upto: 30/9/2025

Company FMC Standard Employee

Name: Network No: Nationality:Philippine



Clinical Details:	Temp <mark>38.5</mark>	B.P. <mark>110</mark>	Pulse. 108
Signs & Symptoms: risk of	of fall		
Date of Onset Illness :		○ Emergency ○ Work	related O New visit O Follo
Diagnosis: J03.90 - Acute	e tonsillitis, unspecified, R52 - Pa	ain, unspecified, R51.9 - Headache, un	specified, R05 - Cough, E86.0 -
K29.60 - Other gastritis v	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,0125-12210 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 (DOME, BOTTLE), Pharma CEFTRIAXONE-TABUK IV, Pharmacy,85027, COMPLETE CBC AUTOMATED, Lab,96365, IV INFUSION THERAPY/HR, Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH, Co.Pay,9, Consultation Gp, General Consultation,96361, ON, Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM, Co.Pay,0005-149902-1021, CLOFEN, Pharmacy Signature with seal:

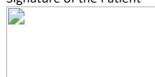
راني باديبورايل ثارا Dr. Keerthana Rani Padipl General Practit License No.: 37864 يتيكير الطبي ذم م CITICARE MEDICAL C

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 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