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 Name: FMC Standard Network Employee No: _____Nationality:Philippine

Clinical Details: Temp38.5 B.P.110 Pulse. 108
Signs & Symptoms: risk of fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follov
Diagnosis: J03.90 - Acute tonsillitis, unspecified, R52 - Pain, unspecified, R51.9 - Headache, unspecified, R05 - Cough, E86.0 - D
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 00ML, 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

Doctor's Name: KEERTHANA signature with seal:

راني باديبورايل ثارا
Dr. Keerthana Rani Padip
General Practi
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, 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 |