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: 25-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1988-1594872-8
Card Holder's Name: MICHELLE SABALAN Age: 37Y - 2M - 2D 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: Temp37.2 B.P.100 Pulse. 82
Signs & Symptoms: risk of fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up visit
Diagnosis: J03.90 - Acute tonsillitis, unspecified, R50.9 - Fever, unspecified, R07.0 - Pain in throat, I95.9 - Hypotension, unspecified, E86.0 - Dehydration, R51.9 - Headache, unspecified

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

9.01, Free Follow-Up Consultation Gp , General Consultation,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0384-111908-1001, SODIUM CHLORIDE B.P. , Pharmacy,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,0125-122107-1022, DEX + 2, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Doctor's Name: AISHA signature with seal:

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

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 25-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quantity | Price |
|---|---|---|---|---|
| (PREDNISOLONE : 20 MG) TABLETS | TABLETS (20S, BLISTER PACK) | 5 | 5 | 0.0000 |
| (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS | CAPLETS (24S, BOX) | 5 | 15 | 0.0000 |
| (POVIDONE IODINE : 1%) GARGLE | GARGLE (125ML, BOTTLE) | 5 | 10 | 0.0000 |