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: 784-2004-2462299-9
Card Holder's Name: JEETENDRA JAI RAM Age: 21Y - 0M - 20D Sex: Male
Card Holder's Tel No: Mobile No: 0503586951
Ins Card No: I019-010-122982724-01 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.6 B.P.120 Pulse. 84
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: M25.511 - Pain in right shoulder, M62.838 - Other muscle spasm

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

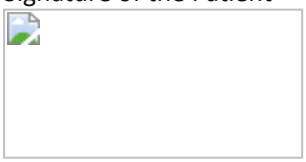
0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/I INJ SC/IM , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9, Consultation Gp , General Consultation

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 25-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(NAPROXEN : 500 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5	10
(SODIUM AESCINATE : 20 MG) TABLETS	TABLETS (40S, BOX)	3	6
(DICLOFENAC DIETHYLAMINE : 11.6 MG/ G) GEL	GEL (50G, TUBE)	5	10