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: 27-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-7719613-5
Card Holder's Name: NARESH THOKALA POSHETTY THOKALA Age: 25Y - 2M - 25D Sex: Male
Card Holder's Tel No: Mobile No: 0529466975
Ins Card No: I005-010-121075925-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 38.5 B.P. 120 Pulse. 98
Signs & Symptoms: risk of fall
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follow up visit
Diagnosis: J30.89 - Other allergic rhinitis, R51.9 - Headache, unspecified, R07.0 - Pain in throat, R05 - Cough, R50.9 - Fever, unspecified, E86.0 - Dehydration

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,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,0384-207801-1002, LACTATED RINGER'S & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION (500ML, BOTTLE) , Pharma : General Consultation,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , (IV INFUSION INIT , Co.Pay

Doctor's Name: KEERTHANA signature with seal:

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مركز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

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 27-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	3	12	0.0000
(TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP	SYRUP (100ML, GLASS BOTTLE)	3	1	0.0000
(LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	3	3	0.0000
(ASCORBIC ACID (VITAMIN C) : 1000 MG) EFFERVESCENT TABLETS	EFFERVESCENT TABLETS (10S, BOX)	5	5	0.0000
(TRIPROLIDINE HCL : 1.25 MG/5ML) (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) SYRUP	SYRUP (100ML, BOTTLE)	5	75	0.0000