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

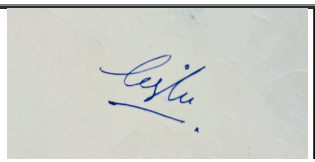
Date: 28-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-2734324-9
Card Holder's Name: DONA SAJANI GAYARA KANDAWALA Age: 29Y - 2M - 19D Sex: Female
Card Holder's Tel No: Mobile No: 971502775824
Ins Card No: I019-010-120845303-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 37 B.P. 110 Pulse. 82
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: R19.7 - Diarrhea, unspecified, E86.0 - Dehydration, I95.9 - Hypotension, unspecified, R10.84 - Generalized abdomin

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

0005-136504-1021, SCOPINAL , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96361, HYDRATE IV INFUSION ADD-O
Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.Pay,0442-116612-1001, (METRONIDAZOLE : 5 MG/ML) SOLUTION FOR INFUS
Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: AISHA signature with seal:



Dr. Aisha U
Physician- General P
DHA- 40131439
CITICARE MEDICA
DUBAI - U.A

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 28-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)