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: 31-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1986-2764743-5
Card Holder's Name: MOHAMED HASSAN MOHAMED ABDELRAHMAN ELSAADANY Age: 39Y - 1M - 5D Sex:Male
Card Holder's Tel No: Mobile No: 0523543663
Ins Card No: I019-010-120233657-02 Valid Upto: 7/6/2026
Company Name:FMC Standard Network Employee No:_____ Nationality:Egyptian

Clinical Details: Temp36.6 B.P.140 Pulse. 81
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: A05.9 - Bacterial foodborne intoxication, unspecified, R50.9 - Fever, unspecified, E86.0 - Dehydration, R11.2 - Nausea with vomiting, unspecified, R12 - Heartburn, R19.7 - Diarrhea, unspecified, K29.00 - Acute gastritis without bleeding, R10.84 - Generalized abdominal pain

Management plan (Services inside the clinic including injections and investigations)
85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,2568-242802-0601, (PANTOPRAZOLE (AS SODIUM) : 40 MG) LYOPHILIZED POWDER FOR INJECTION , Pharmacy,96361, HYDRATE IV INFUSION ADD-ON , Co.Pay,0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,0005-136504-1021, SCOPINAL , Pharmacy,0005-150403-1021, PREMOSAN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0135- [illegible] OR INFUSION , Pharmacy,9, Consultation Gp , General Consultation

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

Doctor's Name: AISHA 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 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 31-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14	2.2900
(METOCLOPRAMIDE : 10 MG) TABLETS	TABLETS (20S, BOX)	5	10	0.0000
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000
(SODIUM CHLORIDE : 2.6 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) (DEXTROSE ANHYDROUS : 13.5 G) POWDER FOR SOLUTION	POWDER FOR SOLUTION (10X21.8G, SACHET)	3	6	0.0000
(ALUMINIUM HYDROXIDE : 225 MG/5ML) (SIMETHICONE : 25 MG/5 ML) (MAGNESIUM HYDROXIDE : 200 MG/5ML) SUSPENSION	SUSPENSION (180ML, PLASTIC BOTTLE)	5	10	0.0000