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

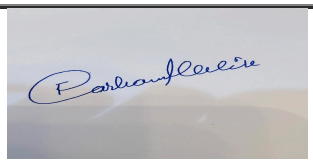
Date: 31-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1984-2147322-8
Card Holder's Name: MD MASUD RANA ABUL KALAM AJAD Age: 40Y - 11M - 27D Sex: Male
Card Holder's Tel No: Mobile No: 0544879300
Ins Card No: I019-010-116845727-02 Valid Upto: 25/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Bangladeshi

Clinical Details: Temp 36.9 B.P. 124 Pulse. 75
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: R21 - Rash and other nonspecific skin eruption, L23.5 - Allergic contact dermatitis due to other chemical products, Allergy, unspecified, initial encounter

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

0005-111805-1021, CHLOROHISTOL 10MG , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmac THER/PROPH/DIAG INJ SC/IM , Co.Pay,85027, COMPLETE CBC AUTOMATED , Lab,9, Consultation Gp , General Consultation

Doctor's Name: Dr.Farhan Iyas signature with seal:



Dr .Frahan Ilyas
Physician-General P
DHA-0644178
CITICARE MEDICAL
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 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 31-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	10	20
(BETAMETHASONE : 0.05%) CREAM	CREAM (10G, TUBE)	5	1