

## 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: 3	31-Ju	1-20	125
---------	-------	------	-----

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-7836810-6 Card Holder's Name: Vishal Kumar Mahinder Singh Age: 32Y - 0M - 1D Sex: Male

Card Holder's Tel No: Mobile No: 0545112718
Ins Card No: I038-010-116778783-01 Valid Upto: 4/5/2026
Company Name: FMC Standard Network Employee No: \_\_\_\_\_\_\_Nationality: Indian



Clinical Details:	Temp <mark>36.8</mark>	B.P. <b>140</b>	Pulse. <mark>84</mark>
Signs & Symptoms: RISK (	OF FALL		
Date of Onset Illness:		○ Emergency ○ Wo	rk related $ \bigcirc $ New visit $ \bigcirc $ Follo
Diagnosis: R11.10 - Vomit	ing, unspecified, R19.7 - Diar	rhea, unspecified, A06.9 - Amebiasis, u	unspecified, A05.9 - Bacterial foo
intoxication, unspecified,	E86.0 - Dehydration		

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

0005-150403-1021, PREMOSAN, Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR, Co.Pay,0439-15290 LACTATED RINGERS INJECTION USP, Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV, Pharmacy,2190-106618-1001, PA 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION FOR INFUSION, Pharmacy,9, Consultation Gp, General Consultation,9636

HYDRATION IV INFUSION INIT , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.P

signature with seal:

Dr .Frahan Ilyas Physician-General F DHA-0644178; CITICARE MEDICAL DUBAI U.A.E

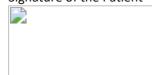
Diagnostic Procedures referred outside:

Doctor's Name: Dr.Farhan Iyas

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, medical 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	Quan
(DOMPERIDONE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK	3	6
(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	3	6
(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	POWDER FOR SOLUTION (10 X 4.4 G, SACHET)	3	3