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: 01-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1987-8304272-8
Card Holder's Name: Jennelyn Deza Arellano Age: 38Y - 0M - 17D Sex: Female
Card Holder's Tel No: Mobile No: 0526800421
Ins Card No: I005-010-116122173-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Philippine

Clinical Details: Temp36.8 B.P.130 Pulse. 70
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follov
Diagnosis: K29.00 - Acute gastritis without bleeding, R07.0 - Pain in throat, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, R Dysphonia

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

0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Phar
135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,0005-242802-0781, PAN
I.V. , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,94640, AIRWAY INHALATION TREATMENT , Co.Pay,96374, THER/PRO
IV PUSH , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp eneral Consultation

Doctor's Name: KEERTHANA 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 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 01-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quan |
|---|---|---|---|
| (PREDNISOLONE : 20 MG) TABLETS | TABLETS (20S, BLISTER PACK) | 5 | 1 |
| (DESLORATADINE : 5 MG) FILM COATED TABLETS | FILM COATED TABLETS (20S, BLISTER) | 5 | 5 |
| (OXOMEMAZINE : 0.33 MG/ML) SYRUP | SYRUP (150ML, PLASTIC BOTTLE) | 5 | 150 |

| Medicine | Dose | Duration | Quan |
|---|---|---|---|
| (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN) | CAPSULES (HARD GELATIN) (14S, BLISTER) | 5 | 5 |