

ANNEXURE V

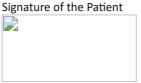
F M C NETWORK UAE

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: 784-1990-6668021-8 Card Holder's Name: PRAPATSORN KERDMARK Age: 34Y - 10M - 26D Sex: Female Card Holder's Tel No: 0506965824 Mobile No: 1005-010-117539996-01 30/9/2025 Valid Upto: Ins Card No: Company Name: FMC Standard Network Employee No: ______ Nationality: Thai Clinical Details: Temp38 B.P.100 Pulse. 99 Signs & Symptoms: Date of Onset Illness: ○ Emergency ○ Work related ○ New visit ○ Follow up visit Diagnosis: M54.5 - Low back pain, N39.0 - Urinary tract infection, site not specified, R50.9 - Fever, unspecified, R30.0 - Dysuria Management plan (Services inside the clinic including injections and investigations) 0005-149902-1021, CLOFEN, Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM, Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE, Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV, Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS/DX 1ST TO 1 Dr. Amaizah Ishtiag General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E Doctor's Name: DR Amaizah 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 abovementioned 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.

Date 01-Aug-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (9S, SACHET)	3	1	0.0000