

**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: 03-Aug-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1996-2135332-7

Card Holder's JIMA ANJANIE WIJENAYAKA

Age: 28Y - 8M - 12D Sex: Female

Name: DOMBAGODA PALLE GEDARA

Card Holder's Tel No:

Mobile No: 0509250321

Ins Card No: I005-010-117760326-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Sri Lankan



Clinical Details:

Temp 36

B.P. 100

Pulse. 86

Signs & Symptoms: Risk of Fall

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified, R05 - Cough, R06.2 - Wheezing, E86.0 - Dehydrati
 Allergic rhinitis, unspecified, R07.0 - Pain in throat

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

85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S
 FOR INFUSION , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PH
 Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372,
 THER/PROPH/DIAG INJ SC/IM , Co.Pay,0102-100104-1001, SODIUM CHLORIDE & D
 INFUSION INIT , Co.Pay,0188-135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/M
 AIRWAY INHALATION TREATMENT , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: AISHA

signature with seal:

Dr. Aisha U
 Physician- General P
 DHA- 40131439
 CITICARE MEDICA
 DUBAI - U.A

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, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 03-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	10
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER PACK)	5	10
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (48S, BOX)	5	15

Medicine	Dose	Duration	Quantity
(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	5	15
(POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION	MOUTHWASH-SOLUTION (250ML, PLASTIC BOTTLE)	3	6