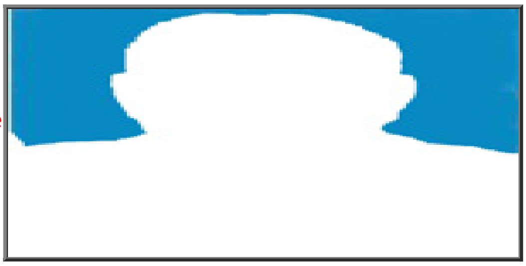
ANNEXURE V

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: 04-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-2395675-1
Card Holder's Name: ADITYA KUMAR SHIVCHANDRA THAKUR Age: 26Y - 5M - 28D Sex: Male
Card Holder's Tel No: Mobile No: 0509502547
Ins Card No: I005-010-120929342-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _________ Nationality: Indian

Clinical Details: Temp 37.1 B.P. 110 Pulse. 80
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R09.81 - Nasal congestion, J06.9 - Acute upper respiratory infection, unspecified, K29.00 - Acute gastritis without bleeding, R52 - Pain, unspecified

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0384-207801-1002, LACTATED RINGER'S & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION (500ML, BOTTLE) , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTIO OR INJECTION , Pharmac FEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,85025, COMPLETE CBC W/AUTO THER/PROPH/DIAG INJ IV PUSH , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96361, HYDRATE IV INF , Consultation Gp , General Consultation

Doctor's Name: KEERTHANA signature with seal:

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذم م
CITICARE MEDICAL CENTER LLC

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 above-mentioned 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.

Signature of the Patient

Date 04-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) (CHLORPHENIRAMINE MALEATE : 2 MG) TABLETS	TABLETS (24S, BLISTER)	3	9	0.0000
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	10	0.0000
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	5	5	0.0000
(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	SYRUP (SUGAR FREE) (100ML, GLASS BOTTLE)	5	150	0.0000
(LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	5	5	0.0000
(XYLOMETAZOLINE HCL (MENTHOL) : 0.1%) LIQUID FOR SPRAY (NASAL)	LIQUID FOR SPRAY (NASAL) (10ML, SPRAY BOTTLE)	5	15	0.0000