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: 07-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2001-4186104-5
Card Holder's Name: KARTHIKA KRISHNADAS KRISHNADAS KOTAIL CHANDRAN Age: 24Y - 4M - 9D Sex: Female
Card Holder's Tel No: Mobile No: 0563651584
Ins Card No: I019-010-120763953-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

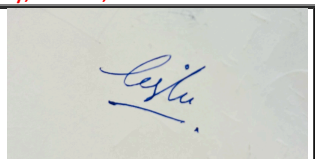
Clinical Details: Temp 36.4 B.P. 110 Pulse. 86
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: K29.00 - Acute gastritis without bleeding, R10.84 - Generalized abdominal pain, R11.0 - Nausea, E86.0 - Dehydratio

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

2568-242802-0601, (PANTOPRAZOLE (AS SODIUM) : 40 MG) LYOPHILIZED POWDER FOR INJECTION , Pharmacy,96374, THER/P
INJ IV PUSH , Co.Pay,0005-136504-1021, SCOPINAL , Pharmacy,0005-150403-1021, PREMOSAN , Pharmacy,96372, THER/PROI
SC/IM , Co.Pay,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co

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

Signature of the Patient

Date 07-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)