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: 13-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1979-1416326-2
Card Holder's Name: I WAYAN SUYADNYA Age: 46Y - 2M - 0D Sex: Male
Card Holder's Tel No: Mobile No: 0508075253
Ins Card No: I019-010-112614572-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____Nationality:Indonesian

Clinical Details: Temp36.6 B.P.140 Pulse. 80
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: J30.89 - Other allergic rhinitis, J02.9 - Acute pharyngitis, unspecified, R07.0 - Pain in throat, R51.9 - Headache, unsp
- Fever, unspecified, R06.09 - Other forms of dyspnea, K29.00 - Acute gastritis without bleeding

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

0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION , Pharma
135906-2441, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,85025, COMPLETE CBC V
WBC , Lab,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,94640, AIRWAY INHALATION TREATMENT , Co.Pay,9, Consultation Gp
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 13-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(DESLORATADINE : 5 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER)	5	5
(XYLOMETAZOLINE HCL (MENTHOL) : 0.1%) LIQUID FOR SPRAY (NASAL)	LIQUID FOR SPRAY (NASAL) (10ML, SPRAY BOTTLE)	5	15
(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (6S, BLISTER)	5	5

Medicine	Dose	Duration	Quant
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	5	5
(OXOMEMAZINE : 0.33 MG/ML) SYRUP	SYRUP (150ML, PLASTIC BOTTLE)	5	150
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (96S, BLISTER PACK)	2	4
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	3	6