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

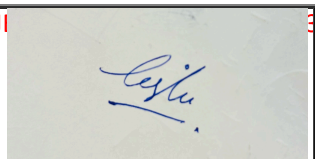
Medical Expenses Claim form

Date: 19-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1972-6585952-6
Card Holder's Name: MONIA BEN NEJMA EP ALIJABI Age: 52Y - 8M - 9D Sex: Female
Card Holder's Tel No: Mobile No: 0501465907
Ins Card No: I038-010-118639628-01 Valid Upto: 1/9/2025
Company Name: FMC Standard Network Employee No:_____ Nationality: Tunisian

Clinical Details: Temp 36.6 B.P. 120 Pulse. 64
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R07.0 - Pain in throat, R51.9 - Headache, unspecified, R50.9 - unspecified, M79.10 - Myalgia, unspecified site, R09.81 - Nasal congestion, E86.0 - Dehydration

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,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,963 THER/PROPH/DIAG INJ SC/IM , Co.Pay,0439-152905-1001, LACTATED RINGERS INJ ADD-ON , Co.Pay,9, Consultation Gp , General Consultation



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

Doctor's Name: AISHA 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 19-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quan |
|---|---|---|---|
| (IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY | NASAL SPRAY ( 10ML, HDPE BOTTLE METERED DOSE SPRAY PUMP) | 5 | 1 |
| (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS | CAPLETS (24S, BOX) | 5 | 15 |
| (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION | SPRAY SOLUTION (30ML, SPRAY BOTTLE) | 3 | 6 |

| Medicine | Dose | Duration | Quan |
|---|---|---|---|
| (AZITHROMYCIN : 500 MG) FILM COATED TABLETS | FILM COATED TABLETS (3S, BLISTER PACK) | 5 | 10 |