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

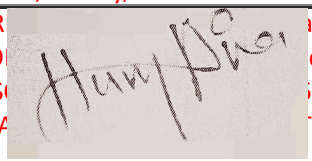
Medical Expenses Claim form

Date: 13-Oct-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-6135536-5
Card Holder's Name: YAKUWA SARU MAGAR Age: 28Y - 11M - 2D Sex: Male
Card Holder's Tel No: Mobile No: 0529099626
Ins Card No: I019-010-119026412-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Nepalese

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Follov
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecifie
Acute gastritis without bleeding, R05 - Cough

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SO
INJECTION , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION
INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,1393-135904-2441, (BUDESONID
MG/2ML) SUSPENSION FOR NEBULIZATION , Pharmacy,0195-107704-0801, CEFTR
DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTIO
THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ S
(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION , Pharmacy,94640, A



Dr. Humaira M
General Practit
DHA No: 541555
CITICARE MEDICAL
DUBAI - U.A

Doctor's Name: Humaira
Gp , General Consultation
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-Oct-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	1
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	10	10
(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12

Medicine	Dose	Duration	Quant
(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (14S, BLISTER)	7	14
(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	SYRUP (ALCOHOL FREE) (100ML, GLASS BOTTLE)	1	1