ANNEXURE V

F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, P. O. BOX: 127452, ABU DHABI
Tel – 04 3977841, Fax – 04 3977842
Email – claims@fmchealthcare.ae Toll Free: 800 3426

Reimbursement Medical Expenses Claim form

(Emergency Only)

Date: 30-Jul-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1994-2299080-6
Card Holder's Name: ADNAN YAQOOB Age: 30Y - 0M - 27D Sex: Male
Card Holder's Tel No: Mobile No: 0566465723
Ins Card No: I019-010-118915814-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details: Temp36.1 B.P.136 Pulse. 96
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: L01.00 - Impetigo, unspecified, L02.422 - Furuncle of left axilla, L02.93 - Carbuncle, unspecified

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

Doctor's Name: Enomen Goodluck 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 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 30-Jul-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	14	0.0000
(FEXOFENADINE HCL : 120 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	15	30	0.0000