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

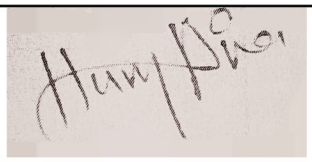
Date: 02-Aug-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1988-4593849-1
Card Holder's Name: ANGELIQUE ESCOLO SUMILLANO Age: 36Y - 2M - 11D Sex: Female
Card Holder's Tel No: Mobile No: 0586834733
Ins Card No: I005-010-120157466-01 Valid Upto: 6/9/2024
Company Name: FMC Standard Network Employee No: _____ Nationality: Philippine

Clinical Details: Temp 36.7 B.P. 140 Pulse. 88
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: N93.9 - Abnormal uterine and vaginal bleeding, unspecified

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

9, Consultation Gp , General Consultation

Doctor's Name: Humaira 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 a 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, medical medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 02-Aug-2024

Pharmaceuticals (to be filled by treating doctor only)