

**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 formDate: **06-Aug-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1994-6247690-6**Card Holder's Name: **NARJISSE BOULAOUANE** Age: **29Y - 8M - 18D** Sex: **Female**Card Holder's Tel No: Mobile No: **0568994275**Ins Card No: **I019-010-118580729-01** Valid Upto: **7/6/2025**Company **FMC Standard** Employee _____ Nationality: **Moroccan**
 Name: **Network** No: _____Clinical Details: Temp **37.1** B.P. **100** Pulse. **80**Signs & Symptoms: **RISK FOR FALL**Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow upDiagnosis: **N39.0 - Urinary tract infection, site not specified, R07.0 - Pain in throat**

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

81015, MICROSCOPIC EXAM OF URINE , Lab,9, Consultation Gp , General ConsultationDoctor's Name: **Humaira**

signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTRE
 DUBAI - U.A.E.

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 a person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **06-Aug-2024**

Pharmaceuticals (to be filled by treating doctor only)