

## ANNEXURE V

## 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

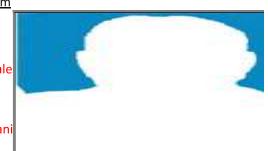
| Date:  | TZ-Ang- | -2024 |
|--------|---------|-------|
| Clinic | Name:   | CITIC |

CARE MEDICAL CENTER LLC Emirates: 784-1986-9259365-4 Card Holder's Name: RIZWAN SHAUKAT SHAUKAT HAYAT Age: 38Y - 0M - 1D Sex: Male

Card Holder's Tel No: Mobile No: 0561822024

Ins Card No: 1019-010-115402254-01 Valid Upto: 7/6/2025

Company FMC Standard **Employee** Nationality: Pakistani Name: Network No:



| Clinical Details:             | Temp <mark>37.2</mark>         | B.P. <mark>124</mark>                    | Pulse. <mark>80</mark>         |
|-------------------------------|--------------------------------|--|--------------------------------|
| Signs & Symptoms: risk for fa | all                            |  |                                |
| Date of Onset Illness :       |                                | $\bigcirc$ Emergency $\bigcirc$ Work re  | elated O New visit O Follow up |
| Diagnosis: M00.871 - Arthriti | is due to other bacteria, righ | t ankle and foot, M10.9 - Gout, unspecif | fied, R52 - Pain, unspecified  |

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

96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0005-149902-1021, CLOFEN , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXI TO 1 HR , Co.Pay,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,9, Consultation Gp , General Consultation



Dr. Enomen Goodluck I **General Practitioner** DHA No: 28040827-00 CITICARE MEDICAL CENTE DUBAI - U.A.E.

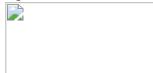
Doctor's Name: Enomen Goodluck

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 con medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 12-Aug-2024



Pharmaceuticals (to be filled by treating doctor only)

| Medicine                     | Dose                        | Duration | Quantity | Pr |
|------------------------------|-----------------------------|----------|----------|----|
| (IBUPROFEN : 400 MG) TABLETS | TABLETS (24S, BLISTER PACK) | 6        | 18       | 0. |