



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-Aug-2024

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1991-5073617-3

Card Holder's Name: SCOVIA NABUKWASI

Age: 33Y - 6M - 8D Sex: Female

Card Holder's Tel No:

Mobile No:

0568133104

Ins Card No: I019-010-117215415-01

Valid Upto: 7/2/2025

Company FMC Standard

Employee

Name: Network

No:

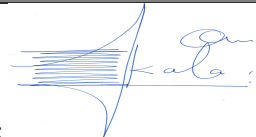
Nationality: Ugandan



Clinical Details:	Temp	B.P.	Pulse.
Signs & Symptoms:			
Date of Onset Illness :		☐ Emergency	☐ Work related
		☐ New visit	☐ Follow up visit
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified			

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

9, Consultation Gp , General Consultation

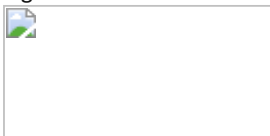
Doctor's Name: Enomen Goodluck	signature with seal:		Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.
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Diagnostic Procedures referred outside:

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 13-Aug-2024



Pharmaceuticals (to be filled by treating doctor only)