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: 04-Sep-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-0584161-0
Card Holder's Name: Syed Basit Hussain Age: 28Y - 2M - 18D Sex: Male
Card Holder's Tel No: Mobile No: 0526186434
Ins Card No: I019-010-120345356-01 Valid Upto: 7/6/2025
Company Name:FMC Standard Network Employee No:_____ Nationality:Pakistani

Clinical Details: Temp36.3 B.P.103 Pulse. 66
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: R51.9 - Headache, unspecified, E86.0 - Dehydration

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

0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,0005-1499
CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , C
Consultation Gp , General Consultation

Doctor's Name: Humaira signature with seal:

Dr. Humaira M
General Practiti
DHA No: 541555
CITICARE MEDICAL C
DUBAI - U.A.

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 04-Sep-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (50S, SACHET)	5	5