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: 14-Sep-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-5959508-5
Card Holder's Name: RAHUL SINGH SINOD KUMAR SINGH Age: 24Y - 11M - 11D Sex: Male
Card Holder's Tel No: Mobile No: 054449118
Ins Card No: I019-010-118433320-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 36.9 B.P. 119 Pulse. 106
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: M25.511 - Pain in right shoulder, E55.9 - Vitamin D deficiency, 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
General Practitioner
DHA No: 28040827-00
CITICARE MEDICAL CENTE
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 abo 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 cor medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 14-Sep-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(DICLOFENAC SODIUM : 1%) GEL	GEL (30G, TUBE)	15	1
(ETORICOXIB : 120 MG) FILM COATED TABLETS	FILM COATED TABLETS (7S, BLISTER PACK)	7	7

Medicine	Dose	Duration	Quantity
(CHOLECALCIFEROL : 10000 IU) SOFT GELATIN CAPSULES	SOFT GELATIN CAPSULES (30S, HDPE BOTTLE)	30	1