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: 05-Oct-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-5037981-1
Card Holder's Name: ARSAL MEHMOOD BUTTAR AFZAAL AHMAD Age: 26Y - 2M - 16D Sex: Male
Card Holder's Tel No: Mobile No: 971567374320
Ins Card No: I019-010-118280343-01 Valid Upto: 30/11/2024
Company Name: FMC Standard Network 3 Employee No: _____ Nationality: Pakistani

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: R07.9 - Chest pain, unspecified, M25.519 - Pain in unspecified shoulder, I20.9 - Angina pectoris, unspecified

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

93000, ECG ROUTINE ECG W/LEAST 12 LDS W/I&R , Co.Pay,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 co medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 05-Oct-2024

Pharmaceuticals (to be filled by treating doctor only)