

**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 formDate: **20-Oct-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-2000-1116850-5**Card Holder's Name: **MYAT YAMIN KHIN**Age: **24Y - 7M - 4D** Sex: **Female**

Card Holder's Tel No:

Mobile No:

0586205766Ins Card No: **I019-010-121177970-01**Valid Upto: **7/6/2025**Company **FMC Standard**

Employee

Name: **Network**

No:

Nationality: **Myanmarese**

Clinical Details:

Temp **37**B.P. **100**Pulse. **66**Signs & Symptoms: **risk for fall**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow
Diagnosis: **T78.40XA - Allergy, unspecified, initial encounter**

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

9, Consultation Gp , General ConsultationDoctor's Name: **Humaira**

signature with seal:

Dr. Humaira M
 General Practitioner
 DHA No: 541555
 CITICARE MEDICAL I
 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 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 services and copies of all medical and Clinic records.

Signature of the Patient

Date **20-Oct-2024**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5