



ANNEXURE V

F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, P. O. BOX: 127452, ABU DHABI

Tel – 04 3977841, Fax – 04 3977842

Email – claims@fmchealthcare.ae Toll Free: 800 3426

Reimbursement Medical Expenses Claim form

(Emergency Only)

Date: 26-Oct-2024

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1981-4260860-7

Card Holder's Name: MOISES ANGELO DA SILVEIRA Age: 42Y - 10M - 10D Sex: Male

Card Holder's Tel No: Mobile No: 0505097578

Ins Card No: I017-010-119304765-01 Valid Upto: 2/5/2025

Company Name: FMC Standard Network Employee No: Nationality: Brazilian



Clinical Details:

Temp 36

B.P. 100

Pulse. 68

Signs & Symptoms: RISK OF FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis: K51.911 - Ulcerative colitis, unspecified with rectal bleeding, K62.5 - Hemorrhage of anus and rectum, R42 - Dizziness and giddiness, R55 - Syncope and collapse

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

96360, HYDRATION IV INFUSION INIT , Co.Pay

Doctor's Name: Enomen Goodluck

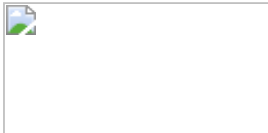
signature with seal:

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 26-Oct-2024



Pharmaceuticals (to be filled by treating doctor only)