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: Temp36 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)