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

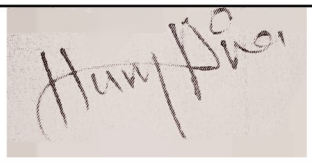
Date: 27-Oct-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-5538336-5
Card Holder's Name: JACQUELINE TABU OMAR Age: 29Y - 5M - 8D Sex: Female
Card Holder's Tel No: Mobile No: 0522702938
Ins Card No: I019-010-118312395-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No:_____Nationality: Kenyan

Clinical Details: Temp36.6 B.P.100 Pulse. 58
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: S61.209A - Unsp open wound of unsp finger w/o damage to nail, init

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

51.01, Non-Surgical Cleansing With Surgical Dressing 16 Sq Inches / 100 Sq Centimeters Or Less , General Consultation,9, Cons
General Consultation

Doctor's Name: Humaira 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 a
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
medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 27-Oct-2024

Pharmaceuticals (to be filled by treating doctor only)