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

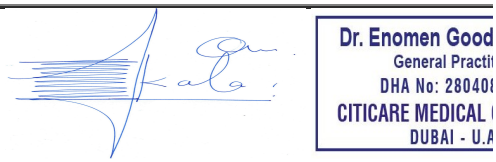
Date: 31-Oct-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-4528321-9
Card Holder's Name: RAVI KUMAR SHERESTHA Age: 27Y - 4M - 4D Sex: Male
Card Holder's Tel No: Mobile No: 0501206121
Ins Card No: I005-010-121540552-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Nepalese

Clinical Details: Temp 36.8 B.P. 121 Pulse. 67
Signs & Symptoms: risk of fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: A02.0 - Salmonella enteritis

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

9, Consultation Gp , General Consultation

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 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 31-Oct-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(METRONIDAZOLE : 500 MG TABLETS	TABLETS (20S, BLISTER PACK	10	20