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

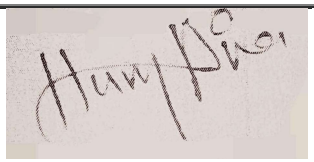
Date: 03-Nov-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-2653693-6
Card Holder's Name: SAIFUL ISLAM Age: 23Y - 10M - 18D Sex: Male
Card Holder's Tel No: Mobile No: 0557585940
Ins Card No: I005-010-119768242-01 Valid Upto: 30/9/2025
Company Name: FMC NETWORK UAE MANAGEMENT CONSULTANCY Employee No: _____Nationality:Bangladeshi

Clinical Details: Temp36.6 B.P.110 Pulse. 58
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: M25.512 - Pain in left shoulder, S23.420A - Sprain of sternoclavicular (joint) (ligament), init encntr

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

9, Consultation Gp , General Consultation,93000, ELECTROCARDIOGRAM COMPLETE , Co.Pay

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 abo mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or a person who has provided medical services to me to furnish any and all information with regard to any medical history, medical cor medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 03-Nov-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	P
(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (100G, TUBE)	1	1	0