

**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: 04-Nov-2024

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-2001-3938332-5

Card Holder's Name: BINOD THADARAI

Age: 23Y - 8M - 9D Sex: Male

Card Holder's Tel No:

Mobile No: 0525411818

Ins Card No: I019-010-119982751-01

Valid Upto: 7/6/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Nepalese



Clinical Details:

Temp 36.8

B.P. 110

Pulse. 86

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: M25.521 - Pain in right elbow, E55.9 - Vitamin D deficiency, unspecified, R53.1 - Weakness

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

9, Consultation Gp , General Consultation

Doctor's Name: Enomen Goodluck

signature with seal:

Dr. Enomen Goodluck
 General Practitioner
 DHA No: 280408
 CITICARE MEDICAL CENTER
 DUBAI - U.A.E

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 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 services and copies of all medical and Clinic records.

Signature of the Patient

Date 04-Nov-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (9S, SACHET)	5	10