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: 08-Nov-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1966-6398421-7
Card Holder's Name: MAJEED MASIH SARDAR MASIH Age: 58Y - 10M - 5D Sex: Male
Card Holder's Tel No: Mobile No: 0505140326
Ins Card No: I005-010-116125749-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Pakistani

Clinical Details: Temp 36.7 B.P. 150 Pulse. 88
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: E11.42 - Type 2 diabetes mellitus with diabetic polyneuropathy, E78.5 - Hyperlipidemia, unspecified, I10 - Essential hypertension

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

9, Consultation Gp , General Consultation

Doctor's Name: Humaira signature with seal:

Dr. Humaira M
General Practit
DHA No: 541555
CITICARE MEDICAL
DUBAI - U.A

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, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 08-Nov-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(LOSARTAN POTASSIUM : 50 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	30	30