

**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 formDate: **08-Nov-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1998-5076760-1**Card Holder's Name: **Anjali Lama** Age: **26Y - 9M - 16D** Sex: **Female**Card Holder's Tel No: Mobile No: **0507823227**Ins Card No: **I005-010-120175024-01** Valid Upto: **30/9/2025**Company **FMC Standard** Employee _____ Nationality: **Nepalese**
 Name: **Network** No: _____Clinical Details: Temp **36.5** B.P. **140** Pulse. **86**Signs & Symptoms: **RISK OF FALL**Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ FollowDiagnosis: **R42 - Dizziness and giddiness, R03.0 - Elevated blood-pressure reading, w/o diagnosis of htn**

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

0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPI SC/IM , Co.Pay,9, Consultation Gp , General ConsultationDoctor's Name: **Humaira**

signature with seal:

Dr. Humaira M
 General Practitioner
 DHA No: 541555
 CITICARE MEDICAL I
 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 **08-Nov-2024**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(NAPROXEN : 500 MG TABLETS	TABLETS (20S, BLISTER PACK	3	6