

**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: 15-Nov-2024

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-2750969-7

Card Holder's Name: MAHESH RIJAL BINOD KUMAR RIJAL Age: 25Y - 1M - 8D Sex: Male

Card Holder's Tel No:

Mobile No: 0564673569

Ins Card No: I005-010-117246737-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Nepalese



Clinical Details:

Temp

B.P.

Pulse.

Signs & Symptoms:

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: Z48.02 - Encounter for removal of sutures, S81.832A - Puncture wound w/o foreign body, left lower leg, init encntr

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

9.01, Free Follow-Up Consultation Gp , General Consultation

Doctor's Name: Humaira

signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTRE
 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 above 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 condition, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 15-Nov-2024

Pharmaceuticals (to be filled by treating doctor only)