**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

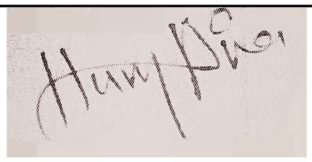
Date: 15-Nov-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-2750969-7
Card Holder's Name: MAHESH RIJAL BINOD KUMAR RIJAL Age:25Y - 1M - 8D Sex:Male
Card Holder's Tel No: Mobile No: 0564673569
Ins Card No: I005-010-117246737-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality:Nepalese

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
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,15851, REMOVE SUTURES DIFF SURGEON , 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 a 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 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)