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: 20-Nov-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1981-4260860-7
Card Holder's Name: MOISES ANGELO DA SILVEIRA Age: 42Y - 11M - 7D Sex: Male
Card Holder's Tel No: Mobile No: 0505097578
Ins Card No: I017-010-119304765-01 Valid Upto: 2/5/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Brazilian

Clinical Details: Temp 36.5 B.P. 100 Pulse. 84
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: I82.501 - Chronic embolism and thombos unsp deep veins of r low extrem, R52 - Pain, unspecified, M79.661 - Pain in ri leg

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 I
General Practitioner
DHA No: 28040827-00
CITICARE MEDICAL CENTE
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 abo 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 co medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 20-Nov-2024

Pharmaceuticals (to be filled by treating doctor only)