



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 - 4D 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
Diagnosis: I82.501 - Chronic embolism and thrombosis of deep veins of right lower extremity, R52 - Pain, unspecified, M79.661 - Pain in leg

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

9, Consultation Gp, General Consultation

Dr. Enomen Goodluck
General Practitioner
DHA No: 280408
CITICARE MEDICAL CENTER
DUBAI - U.A.E.

Doctor's Name: Enomen Goodluck

signature with seal:

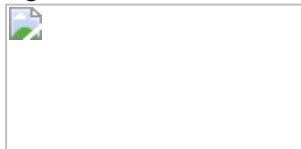
Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the 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 20-Nov-2024



Pharmaceuticals (to be filled by treating doctor only)