**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

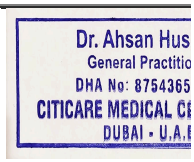
Date: 20-Nov-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-1396146-0
Card Holder's Name: CHRISTINE JOY RONQUILLO BUAN Age: 30Y - 11M - 7D Sex: Female
Card Holder's Tel No: Mobile No: 0501617649
Ins Card No: I019-010-121028772-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Philippine

Clinical Details: Temp 36.5 B.P. 90 Pulse. 86
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: N92.0 - Excessive and frequent menstruation with regular cycle

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

9, Consultation Gp , General Consultation

Doctor's Name: AHSAN HUSSAIN 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, medica 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)