

**ANNEXURE V****F M C NETWORK UAE**

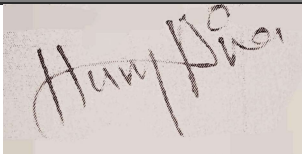
P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
 Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim formDate: **23-Nov-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1999-1045903-3**Card Holder's Name: **MEHDI TAZOUTI** Age: **25Y - 2M - 7D** Sex: **Female**Card Holder's Tel No: Mobile No: **+212678613731**Ins Card No: **I019-010-120692323-01** Valid Upto: **7/6/2025**Company **FMC Standard** Employee
 Name: **Network** No: _____ Nationality: **Moroccan**

Clinical Details:	Temp	B.P.	Pulse.
Signs & Symptoms:			
Date of Onset Illness :		☐ Emergency ☐ Work related ☐ New visit ☐ Follow up	
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, K29.00 - Acute gastritis without bleeding			

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

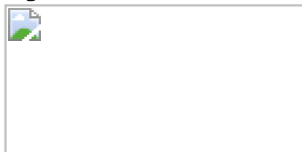
9.01, Free Follow-Up Consultation Gp , General Consultation,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pa 107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM ,

Doctor's Name: Humaira	signature with seal: 	Dr. Humaira Mumta General Practitioner DHA No: 54155530-00 CITICARE MEDICAL CENTRE DUBAI - U.A.E.
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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 conditions and medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **23-Nov-2024**

Pharmaceuticals (to be filled by treating doctor only)

