

**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: **24-Nov-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1998-6155272-9**Card Holder's Name: **SUMANTA DAMAI BILASH**Age: **26Y - 10M - 23D**Sex: **Female**Name: **DAMAI**

Card Holder's Tel No:

Mobile No:

0585818611Ins Card No: **I019-010-121177968-01**Valid Upto: **7/6/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**

Clinical Details:	Temp	B.P.	Pulse.
Signs & Symptoms:			
Date of Onset Illness :		☐ Emergency ☐ Work related ☐ New visit ☐ Follow	
Diagnosis: E86.0 - Dehydration			

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

96360, HYDRATION IV INFUSION INIT , Co.Pay,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,9, GP Cons General Consultation

Doctor's Name: **Humaira**

signature with seal:

Dr. Humaira M
 General Practitioner
 DHA No: 541555
 CITICARE MEDICAL I
 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 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 **24-Nov-2024**

Pharmaceuticals (to be filled by treating doctor only)