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

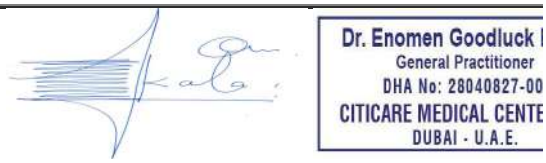
Date: 01-Dec-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1981-5875732-2
Card Holder's Name: MUHAMMAD khurram AZIZ ABDUL AZIZ Age: 43Y - 10M - 16D Sex:Male
Card Holder's Tel No: Mobile No: 0521678612
Ins Card No: I005-010-119448912-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details: Temp36 B.P.110 Pulse. 86
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: L30.9 - Dermatitis, unspecified, B49 - Unspecified mycosis

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

9, Consultation Gp , General Consultation

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 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 01-Dec-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(TERBINAFINE (AS HCL) : 250 MG) TABLETS	TABLETS (14S, BLISTER PACK)	14	14
(BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM	CREAM (20G, COLLAPSIBLE TUBE)	14	1