

ANNEXURE V

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

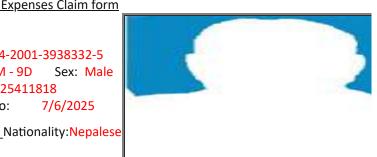
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Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2001-3938332-5 Card Holder's Name: **BINOD THADARAI** Age: 23Y - 9M - 9D Sex: Male

Card Holder's Tel No: 0525411818 Mobile No: Ins Card No: 1019-010-119982751-01 Valid Upto: 7/6/2025

FMC Standard Company Employee

Network Name: No:



Clinical Details:	Temp <mark>36</mark>	B.P. 116	Pulse. <mark>86</mark>
Signs & Symptoms: risk	c of fall		
Date of Onset Illness:		○ Emergency ○ Wo	rk related O New visit O Follow up
Diagnosis: S30.812A - A	Abrasion of penis, initial encounte	er, R52 - Pain, unspecified	

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

9, Consultation Gp , General Consultation

Dr. Enomen Goodluck I General Practitioner DHA No: 28040827-00 CITICARE MEDICAL CENTE DUBAI - U.A.E.

Doctor's Name: Enomen Goodluck

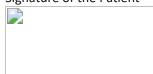
signature with seal:

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 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 cor medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 14-Dec-2024



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14

Medicine	Dose	Duration	Quantity
(PARACETAMOL : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (24S, BLISTER PACK)	4	24