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: 19-Dec-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1990-7131498-5
Card Holder's Name: YAM RAJ GIRI Age: 34Y - 3M - 8D Sex: Male
Card Holder's Tel No: Mobile No: 0543818674
Ins Card No: I005-010-116653001-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Nepalese

Clinical Details: Temp36.8 B.P.116 Pulse. 72
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: M25.512 - Pain in left shoulder, M54.5 - Low back pain, M79.602 - Pain in left arm

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

9, Consultation Gp , General Consultation

Doctor's Name: AHSAN HUSSAIN signature with seal:

Dr. Ahsan Hus
General Practiti
DHA No: 8754365
CITICARE MEDICAL C
DUBAI - U.A.

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

Signature of the Patient

Date 19-Dec-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(IBUPROFEN : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	7	14
(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (50G, TUBE)	14	1