



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: 22-Dec-2024

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1982-0815414-0

Card Holder's Name: TAJ UR RAHMAN

Age: 42Y - 0M - 6D Sex: Male

Card Holder's Tel No:

Mobile No: 0559605660

Ins Card No: I019-010-113204455-02

Valid Upto: 30/11/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Pakistani



Clinical Details:

Temp 36

B.P. 121

Pulse. 79

Signs & Symptoms: risk of fall

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: R29.91 - Unsp symptoms and signs involving the musculoskeletal system, R52 - Pain, unspecified

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

9, Consultation Gp , General Consultation

Doctor's Name: Enomen Goodluck

signature with seal:

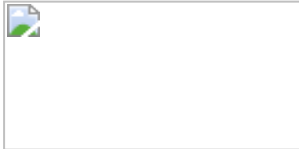
Dr. Enomen Goodluck
General Practitioner
DHA No: 280408
CITICARE MEDICAL CENTER
DUBAI - U.A.E.

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 22-Dec-2024



Pharmaceuticals (to be filled by treating doctor only)