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 Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details: Temp36 B.P.121 Pulse. 79
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
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 Goodl
General Practit
DHA No: 280408
CITICARE MEDICAL (
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 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, medica 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)