

**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 formDate: **26-Dec-2024**Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1987-1307035-1**Card Holder's Name: **RAVINDRA SINGH KUWAR SINGH** Age: **37Y - 6M - 13D** Sex: **Male**Card Holder's Tel No: Mobile No: **0521136986**Ins Card No: **I005-010-119843965-01** Valid Upto: **30/9/2025**Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Indian**Clinical Details: Temp **36.8**B.P. **112**Pulse. **76**Signs & Symptoms: **RISK FOR FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up
Diagnosis: **R22.1 - Localized swelling, mass and lump, neck**

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

9, Consultation Gp , General ConsultationDoctor's Name: **Humaira**

signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTE
 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 above 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 condition, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **26-Dec-2024**

Pharmaceuticals (to be filled by treating doctor only)