

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

B.P.130

Date: 01-Jan-2025

Clinical Details:

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1979-1416326-2 Age: 45Y - 6M - 19D Card Holder's Name: I WAYAN SUYADNYA Sex: Male

Mobile No: Card Holder's Tel No: 0508075253 Ins Card No: 1019-010-112614572-01 Valid Upto: 7/6/2025

Temp36

FMC Standard Company **Employee**

Name: Network No:



Pulse. 91

Signs & Symptoms: RISK OF FALL

Date of Onset Illness: ○ Emergency ○ Work related ○ New visit ○ Follov

Diagnosis: K29.00 - Acute gastritis without bleeding, R10.13 - Epigastric pain, R14.0 - Abdominal distension (gaseous)

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

9, Consultation Gp, General Consultation

Dr. Humaira M **General Practi** CITICARE MEDICAL (DUBAI - U.A

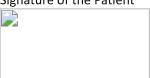
Doctor's Name: Humaira signature with seal:

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 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 01-Jan-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantit
(HYOSCINE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (1000S, BLISTER PACK	3	6