Photo Not Available

Patient 38357 THUPPAHI KASUN UDAYANGA SILVA 784-1999-7605073-4 Repeat
26 Male Sri Lankan S FMC Standard Network - DUBAI INSURANCE COMPANY - Default Scheme (99999)
Medical History (patient_history.aspx?patId=39381)
Billing History (patient_accounts.aspx?patId=39381)

Appointment Visit ID 56642 04-Jan-2025 Humaira - General - DHA-P-54155530
MRN Activities(Log) Insurance Cards EMID Card

Vitals Alert This Patient has Vitals for Temp: 37°C, Pulse: 75bpm, BP: 137mmHg, Height: 170cm, Weight: 63kg, BMI 21.8(Obese), Blood Sugar

Start Time | Nurse Station | Doctor Evaluation | Orthopedic Case Assessment | Diagnosis
Treatments/Procedures | Packages | Prescription | Reimbursement Forms | Documents
Progress Notes | Addendum | FMC FORM | FMC Reimbursement Form | Other Forms | Sick Leave
End Time | Visit Summary Sheet | Nabidh Clinical Docs | Audit Log | Radiology | Laboratory
Health Declaration | Signed Documents | Image Comparison

FMC NETWORK UAE
WE TAKE CARE OF YOU

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: 04-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-7605073-4
Card Holder's Name:THUPPAHI KASUN UDAYANGA SILVA Age:25Y - 6M - 30D Sex:Male
Card Holder's Tel No: Mobile No: 526909186
Ins Card No: I005-010-117311984-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

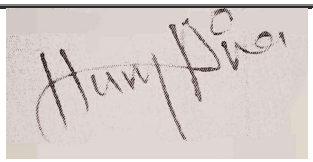
Clinical Details: Temp37 B.P.137 Pulse. 75
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ◯ Emergency ◯ Work related ◯ New visit ◯ Fo

Diagnosis: K29.00 - Acute gastritis without bleeding, R07.9 - Chest pain, unspecified

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

93000, ELECTROCARDIOGRAM COMPLETE , Co.Pay,9, Consultation Gp , General Consultation

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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharm person who has provided medical services to me to furnish any and all information with regard to any medical history, me medical services and copies of all medical and Clinic records.

Signature of the Patient