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

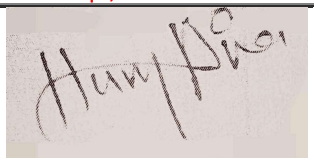
Date: 06-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-3107550-8
Card Holder's Name: SAGAR MANDALA LAXMAN MANDALA Age: 24Y - 10M - 20D Sex: Male
Card Holder's Tel No: Mobile No: 0561324801
Ins Card No: I019-010-118331633-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 37.4 B.P. 130 Pulse. 88
Signs & Symptoms: Risk of Fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: N39.0 - Urinary tract infection, site not specified, R10.30 - Lower abdominal pain, unspecified, R50.9 - Fever, unspecifie
Dehydration

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-136504-1
SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TC
Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9.01, Free Follow-Up 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 the abo
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 co
medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 06-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)