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: 784-1994-3691860-3
Card Holder's Name: RAFAEL ALEXANDRE NUNES DE ALMEIDA Age: 30Y - 10M - 24D Sex: Male
Card Holder's Tel No: Mobile No: 971543542442
Ins Card No: I038-010-121163103-01 Valid Upto: 16/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Portuguese

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: L02.619 - Cutaneous abscess of unspecified foot

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

51.02, Non-Surgical Cleansing With Surgical Dressing Between 16 Sq Inches / 100 Sq Centimeters And 48 Sq Inches / 300 Sq Centi
General Consultation,9.01, Free Follow-Up Consultation Gp , General Consultation

Doctor'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 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)