Photo Not Available

Patient 39262 CAESAR ZALUM MALLILLIA 784-1972-5037419-2 Follow Up 53 Male Philippine M FMC Standard Network - DUBAI INSURANCE COMPANY - Default Scheme (99999)
Medical History (patient_history.aspx?patId=40287)
Billing History (patient_accounts.aspx?patId=40287)

Appointment Visit ID 56711 06-Jan-2025 Humaira - General - DHA-P-54155530
MRN Activities(Log) Insurance Cards EMID Card

Vitals Alert This Patient has Vitals for Temp: 36.8°C, Pulse: 86bpm, BP: 130mmHg, Height: 157cm, Weight: 85kg, BMI 34.48(Obese), Blood Sugar

DHA Re

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

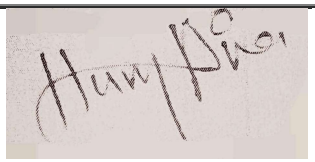
Date: 06-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1972-5037419-2
Card Holder's Name: CAESAR ZALUM MALLILLIA Age: 52Y - 4M - 9D Sex: Male
Card Holder's Tel No: Mobile No: 0501397656
Ins Card No: I005-010-118816759-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Philippine

Clinical Details: Temp36.8 B.P.130 Pulse. 86
Signs & Symptoms: RISK OF FALL
Date of Onset Illness :
Emergency Work related New visit Fo

Diagnosis: M62.838 - Other muscle spasm, R52 - Pain, unspecified

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

9.01, Free Follow-Up Consultation Gp , General Consultation

Doctor's Name: Humaira signature with seal: 

Dr. Huma
General
DHA No:
CITICARE MED
DUBA

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