

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

Date: 07-Jan-202	5
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Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1977-3652195-2

Card Holder's Name: MONICA MWIKALI MUNYAO Age: 47Y - 5M - 11D Sex: Female

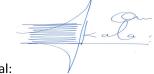
Card Holder's Tel No: 0543831977 Mobile No: Ins Card No: 1019-010-115341080-01 Valid Upto: 7/6/2025 Company Name: FMC Standard Network Employee No: Nationality: Kenyan



Clinical Details:	Temp <mark>36.6</mark>	B.P.138	Pulse. 72
Signs & Symptoms: RISK	FOR FALL		
Date of Onset Illness :		○ Emergency ○ Worl	k related O New visit O Follow
Diagnosis: I10 - Essentia	I (primary) hypertension, Z79.89	9 - Other long term (current) drug the	erapy

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

9, Consultation Gp, General Consultation



Dr. Enomen Good **General Practit** DHA No: 280408 CITICARE MEDICAL (

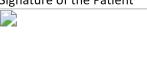
Doctor's Name: Enomen Goodluck signature with seal:

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 07-Jan-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(TELMISARTAN : 80 MG) (AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	TABLETS (28S, BLISTER PACK)	28	28