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

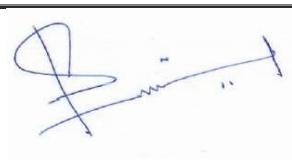
Date: 09-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1994-3691860-3
Card Holder's Name: RAFAEL ALEXANDRE NUNES DE ALMEIDA Age: 30Y - 10M - 18D Sex: Male
Card Holder's Tel No: Mobile No: 971543542442
Ins Card No: I038-010-121163103-01 Valid Upto: 16/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Portuguese

Clinical Details: Temp 36 B.P. 120 Pulse. 86
Signs & Symptoms: RISK OF FALL
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)

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

Doctor's Name: SANDIA 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 09-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	I
(BETAMETHASONE : 0.10% (NEOMYCIN : 0.5% CREAM	CREAM (15G, TUBE	5	1	3