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

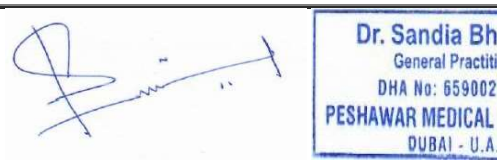
Date: 16-Jan-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2002-8174306-0
Card Holder's Name: ROJU LAMA Age: 22Y - 3M - 18D Sex: Female
Card Holder's Tel No: Mobile No: 0561910904
Ins Card No: I005-010-120721958-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Nepalese

Clinical Details: Temp36.8 B.P.94 Pulse. 74
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: R21 - Rash and other nonspecific skin eruption, E16.2 - Hypoglycemia, unspecified

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

82962, GLUCOSE BLOOD TEST , Lab,9, Consultation Gp , 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 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 16-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantit
(FLUCONAZOLE : 150 MG CAPSULES (HARD GELATIN	CAPSULES (HARD GELATIN (1S, BLISTER PACK	1	1
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	7	7
(TERBINAFINE (AS HCL : 1% CREAM	CREAM (15G, TUBE	10	1