

**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: 22-Jan-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1985-4874694-4

Card Holder's SADAF NADEEM NADEEM

Name: YOUSAF

Age: 39Y - 11M - 10D Sex: Female

Card Holder's Tel No:

Mobile No: 0508946099

Ins Card No: I017-010-121098524-01

Valid Upto: 31/5/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Pakistani



Clinical Details:

Temp 37.1

B.P. 160

Pulse. 100

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow

Diagnosis: I10 - Essential (primary) hypertension

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

9, Consultation Gp , General Consultation

Doctor's Name: Humaira

signature with seal:

Dr. Humaira M
 General Practitioner
 DHA No: 541555
 CITICARE MEDICAL (UAE)
 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 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, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 22-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(TELMISARTAN : 20 MG) TABLETS	TABLETS (30S, BLISTER)	30	30