

**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: 29-Jan-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1989-9061593-6

Card Holder's Name: IVY MAE GIGANTO VILLARDE Age: 35Y - 10M - 15D Sex: Female

Card Holder's Tel No: Mobile No: 0581485435

Ins Card No: I005-010-120176777-01 Valid Upto: 30/9/2025

Company FMC Standard Employee _____ Nationality: Philippine

Name: Network No: _____



Clinical Details: Temp 37.2 B.P. 120 Pulse. 86

Signs & Symptoms: risk of fall

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up

Diagnosis: R52 - Pain, unspecified

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

9, Consultation Gp , General Consultation

Doctor's Name: Humaira

signature with seal:

Dr. Humaira Mumta
 General Practitioner
 DHA No: 54155530-00
 CITICARE MEDICAL CENTE
 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 above 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 condition, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 29-Jan-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (9S, SACHET)	3	9

