

**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: 08-Feb-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1978-1027465-0
Card Holder's Name: LEAH MARCELO APOSTOL Age: 46Y - 9M - 2D Sex: Female
Card Holder's Tel No: Mobile No: 0525696874
Ins Card No: I005-010-116125800-01 Valid Upto: 30/9/2025
Company: FMC Standard Employee No: _____ Nationality: Philippine
Name: Network



Clinical Details: Temp 36.8 B.P. 138 Pulse: 86
Signs & Symptoms: risk of fall
Date of Onset Illness : _____
Diagnosis: I10 - Essential (primary) hypertension, Z79.899 - Other long term (current) drug therapy
☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

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

9, Consultation Gp , General Consultation

Doctor's Name: Humaira

signature with seal:

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
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 any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Signature of the Patient



Date 08-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(LOSARTAN POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	30	30	0.0000