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: 24-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1978-9354760-0
Card Holder's Name: DANIEL NZAU KALOKI Age: 46Y - 4M - 2D Sex: Male
Card Holder's Tel No: Mobile No: 0526626319
Ins Card No: I019-010-115341123-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No:_____Nationality: Kenyan

Clinical Details: Temp36 B.P.184 Pulse. 77
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: I10 - Essential (primary) hypertension

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

84550, ASSAY OF BLOOD/URIC ACID , Lab,9, Consultation Gp , General Consultation

Doctor's Name: Enomen Goodluck signature with seal:

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
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 oth 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 24-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMLODIPINE (AS BESYLATE : 10 MG TABLETS	TABLETS (30S, BLISTER	30	1	1.5700