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

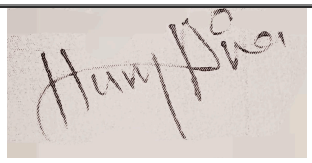
Date: 08-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-2656768-4
Card Holder's Name: AHMAD JAMAL QAISAR KHALIL Age: 31Y - 9M - 2D Sex: Male
Card Holder's Tel No: Mobile No: 0522795599
Ins Card No: I019-010-118620467-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details: Temp36 B.P.107 Pulse. 62
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up
Diagnosis: L20.84 - Intrinsic (allergic) eczema, T78.40XS - Allergy, unspecified, sequela

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

0005-111805-1021, CHLOROHISTOL 10MG , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,85027, COMPLETE CBC AUTO Lab,9, Consultation Gp , General Consultation

Doctor's Name: Humaira 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 abo 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 co medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 08-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	I
(LORATADINE : 10 MG TABLETS	TABLETS (10S, BLISTER PACK	30	30	(

Medicine	Dose	Duration	Quantity	I
(CALCIPOTRIOL : 50 MCG/G (BETAMETHASONE (AS DIPROPIONATE : 0.5 MG/G GEL	GEL (30G, HDPE BOTTLE	30	1	1