Photo Not Available

Patient | 34263 | SAWARAN CHAND | 784-1996-8340056-0 | Follow Up | 29 | Female | Indian | S | FMC Standard Network - DUBAI INSURANCE COMPANY - Default Scheme (99999) | Medical History (patient_history.aspx?patId=33082) | Billing History (patient_accounts.aspx?patId=33082)

Appointment | Visit ID 59885 | 09-Mar-2025 | AISHA - General - DHA-P-40131439 | MRN Activities(Log) | Insurance Cards | EMID Card

Vitals Alert This Patient has Vitals for Temp: 36.7°C, Pulse: 86bpm, BP: 120mmHg, Height: 0cm, Weight: 0kg, BMI 0(Obese), Blood Sugar

Start Time | Nurse Station | Doctor Evaluation | Orthopedic Case Assessment | Diagnosis | Treatments/Procedures | Packages | Prescription | Reimbursement Forms | Documents | Progress Notes | Addendum | FMC FORM | FMC Reimbursement Form | Other Forms | Sick Leave | End Time | Visit Summary Sheet | Nabidh Clinical Docs | Audit Log | Radiology | Laboratory | Health Declaration | Signed Documents | Image Comparison

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: 09-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-8340056-0
Card Holder's Name: SAWARAN CHAND Age: 28Y - 7M - 8D Sex: Female
Card Holder's Tel No: 971589522956 Mobile No: 0589522956
Ins Card No: I005-010-117490735-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details:	Temp36.7	B.P.120	Pulse. 86
Signs & Symptoms: risk of fall			
Date of Onset Illness :		◯ Emergency ◯ Work related ◯ New visit ◯ Fo	

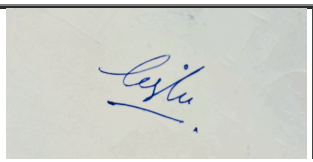
Diagnosis: L50.0 - Allergic urticaria, T78.40XD - Allergy, unspecified, subsequent encounter

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

82785, ASSAY OF IGE , Lab,85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM

Doctor's Name: AISHA

signature with seal:



Dr. Ais
Physician- Ge
DHA- 40
CITICARE ME
DUBA

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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharm person who has provided medical services to me to furnish any and all information with regard to any medical history, me medical services and copies of all medical and Clinic records.

Signature of the Patient