



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: 784-1992-3727502-1

Card Holder's Name: GOKULAKRISHNAN JEYAGOPI Age: 32Y - 9M - 13D Sex: Male

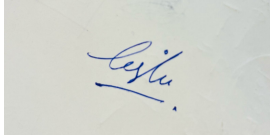
Card Holder's Tel No: Mobile No: 0543028449

Ins Card No: I005-010-116122339-01 Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: Nationality: Indian



Clinical Details:	Temp 36.5	B.P. 158	Pulse. 79
Signs & Symptoms:			
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis:	I10 - Essential (primary) hypertension		

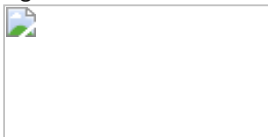
Management plan (Services inside the clinic including injections and investigations)	
9, Consultation Gp , General Consultation	
Doctor's Name: AISHA	signature with seal: 
Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	

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 09-Mar-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMLODIPINE (AS BESYLATE : 5 MG TABLETS	TABLETS (30S, BLISTER	30	1	0.0000