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

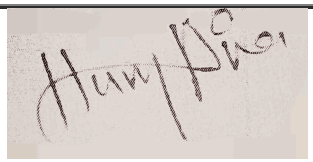
Date: 12-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1977-8405741-8
Card Holder's Name: JUDE DERRICK PEREIRA Age: 28Y - 0M - 18D Sex: Male
Card Holder's Tel No: Mobile No: 0555274237
Ins Card No: I005-010-121540581-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.4 B.P.118 Pulse. 74
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: T78.40XD - Allergy, unspecified, subsequent encounter, L50.9 - Urticaria, unspecified, R09.81 - Nasal congestion

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

Signature of the Patient

Date 12-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(AZELASTINE HCL : 1 MG/ML) NASAL AEROSOL SPRAY	NASAL AEROSOL SPRAY (10ML, SPRAY BOTTLE)	7	1