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

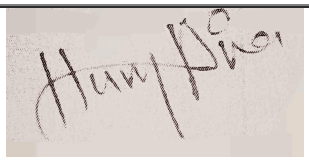
Date: 20-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1972-6585952-6
Card Holder's Name: MONIA BEN NEJMA EP ALIJABI Age: 52Y - 3M - 10D Sex: Female
Card Holder's Tel No: Mobile No: 0501465907
Ins Card No: I038-010-118639628-01 Valid Upto: 1/9/2025
Company Name: FMC Standard Network Employee No:_____ Nationality: Tunisian

Clinical Details: Temp 36.5 B.P. 105 Pulse. 74
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow
Diagnosis: J02.9 - Acute pharyngitis, unspecified, R52 - Pain, unspecified, R05 - Cough, R06.2 - Wheezing

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

94640, AIRWAY INHALATION TREATMENT , Co.Pay,0006-402803-2071, VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBU SOLUTION , Pharmacy

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

Signature of the Patient

Date 20-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)