ANNEXURE V

F M C NETW

P. O. BOX: 50430, DUBAI, **Tel** – (
Email – approval@fmchealthcare.ae

Medical Expenses Claim for

Date: 22-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1987-6073519-5
Card Holder's Name: MEHWISH SABA Age: 38Y - 1M - 17D Sex: Female
Card Holder's Tel No: Mobile No: 0508361939
Ins Card No: I005-010-121964898-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Pakista

Clinical Details: Temp36.9 B.P.100
Signs & Symptoms:
Date of Onset Illness : ○ Emergenc
Diagnosis: R10.9 - Unspecified abdominal pain, R52 - Pain, unspecified, R03.1 - Non

Management plan (Services inside the clinic including injections and investigation

0005-136504-1021, SCOPINAL , Pharmacy,0102-152902-1001, LACTATED RINGERS I
THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96361, HYDRATE IV INFUSION AD
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 se
mentioned examination/Investigation/therapy is given to me by the doctor. I hereb
person who has provided medical services to me to furnish any and all information
medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 22-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose
(HYOSCINE : 10 MG FILM COATED TABLETS	FILM COATED TABLETS (2
(CIPROFLOXACIN : 250 MG) FILM COATED TABLETS	FILM COATED TABLETS (1
(SERRAPEPTASE : 10 MG) TABLETS	TABLETS (30S, BLISTER)