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

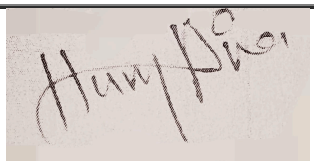
Date: 27-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-4224040-2
Card Holder's Name: HARI MOHAN SINGH PURAN SINGH Age: 26Y - 11M - 17D Sex: Male
Card Holder's Tel No: Mobile No: 0553780238
Ins Card No: I019-010-120285342-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follo
Diagnosis: L03.90 - Cellulitis, unspecified, R52 - Pain, unspecified

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

51.01, Non-Surgical Cleansing With Surgical Dressing 16 Sq Inches / 100 Sq Centimeters Or Less , General Consultation,9.01, Consultation Gp , 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, Pharmac person who has provided medical services to me to furnish any and all information with regard to any medical history, medic medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 27-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)