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: 31-Mar-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2003-4076685-4
Card Holder's Name: FATEMATUZ ZAHARA MD MASUD SAHEED Age: 21Y - 8M - 17D Sex: Female
Card Holder's Tel No: Mobile No: 0542411246
Ins Card No: I019-010-121885621-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Bangladeshi

Clinical Details: Temp 36.9 B.P. 129 Pulse. 87
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: F41.9 - Anxiety disorder, unspecified, R00.2 - Palpitations, G47.00 - Insomnia, unspecified

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

9, Consultation Gp , General Consultation

Doctor's Name: Humaira signature with seal:

Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
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 31-Mar-2025

Pharmaceuticals (to be filled by treating doctor only)