



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

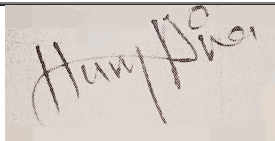
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2003-4076685-4
Card Holder's Name: FATEMATUZ ZAHARA MD MASUD Age: 21Y - 8M - 17D Sex: Female
SAHEED
Card Holder's Tel No: Mobile No: 0542411246
Ins Card No: I019-010-121885621-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Employee No: Nationality: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



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

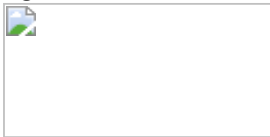
Doctor's Name: Humaira signature with seal: 


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)

