

ANNEXURE V

FMCNETWORKUAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842 Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim form

Dai	te:	09-	Apr-	2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-1004570-1 Card Holder's Name: SHUBHAM RAVINDRA PANDIT Age: 27Y - 7M - 22D Sex: Male

Card Holder's Tel No: Mobile No: 0543199105
Ins Card No: 1005-010-120796696-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: ______ Nationality: Indian



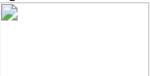
Clinical Details:	Temp36.5	B.P. <mark>120</mark>	Pulse. <mark>99</mark>
Signs & Symptoms: risk for Date of Onset Illness:	or fall	○ Emergency ○ M/c	ork related O New visit O Follow
	congestion, J30.89 - Other alle		ork related O New Visit O Follow
Management plan (Serv	vices inside the clinic including	injections and investigations)	
9, Consultation Gp , Gene	ral Consultation		
			Dr. Aisha U Physician- General P DHA- 40131439 CITICARE MEDICA
Doctor's Name: AISHA		signature with seal:	DUBAI - U.A

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, Pharmacy 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 09-Apr-2025



Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY	NASAL SPRAY (10ML, HDPE BOTTLE METERED DOSE SPRAY PUMP)	7	14
(MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (28S, BLISTER PACK)	5	5