



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: 11-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1989-0281983-2

Card Holder's Name: bhupendra kumar

Age: 35Y - 9M - 13D Sex: Male

Card Holder's Tel No:

Mobile No:

0543971634

Ins Card No: I005-010-119899044-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Nepalese



Clinical Details:

Temp 36.9

B.P. 120

Pulse. 52

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

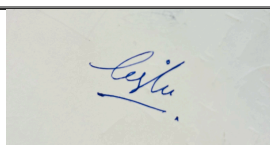
Diagnosis: R00.1 - Bradycardia, unspecified, R03.1 - Nonspecific low blood-pressure reading

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

93000, ELECTROCARDIOGRAM COMPLETE , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: AISHA

signature with seal:



Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
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 11-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)