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: 14-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1994-8502700-2
Card Holder's Name: LUKE KNOX Age: 30Y - 8M - 13D Sex: Male
Card Holder's Tel No: Mobile No: 0585233918
Ins Card No: I005-010-122181986-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: South African

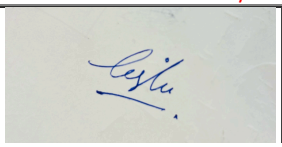
Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
Diagnosis:

○ Emergency ○ Work related ○ New visit ○ Follow up visit

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

9, Consultation Gp , General Consultation,96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0003-122102-1161, (DEXAMETHASONE : 0.1 MG/ML) SYRUP , Pharmacy

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 14-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)