



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: 23-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-6546080-4

Card Holder's Name: NI KADEK PURNAMAYANTI DEWI Age: 26Y - 9M - 14D Sex: Female

Card Holder's Tel No: Mobile No: 971566442706

Ins Card No: I005-010-118993851-01 Valid Upto: 30/9/2025

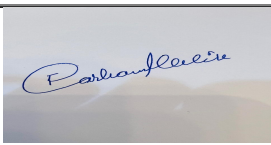
Company Name: FMC Standard Network Employee No: Nationality: Indonesian



Clinical Details: Temp 37.5 B.P. 115 Pulse: 72
Signs & Symptoms: risk of fall
Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
Diagnosis: S90.812D - Abrasion, left foot, subsequent encounter, M25.572 - Pain in left ankle and joints of left foot

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

0005-149902-1021, CLOFEN , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co. Pay, 9, Consultation Gp , General Consultation

Doctor's Name: Dr. Farhan Ilyas signature with seal: 

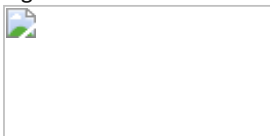
Dr. Farhan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

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 23-Apr-2025



Pharmaceuticals (to be filled by treating doctor only)