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

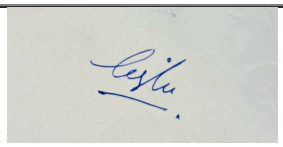
Date: 25-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-4986703-2
Card Holder's Name: MANOHAR MOROLLU MALLESH Age: 25Y - 9M - 11D Sex: Male
Card Holder's Tel No: Mobile No: +919182875582
Ins Card No: I005-010-120929338-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, R05 - Cough, R53.1 - Weakness, J30.9 - Allergic rhinitis, unspecified

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

94640, AIRWAY INHALATION TREATMENT , Co.Pay,9.01, Free Follow-Up 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 25-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)