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: 27-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-3439699-9
Card Holder's Name: SHUJAAT KHAN ZAREEF KHAN Age: 27Y - 8M - 1D Sex: Male
Card Holder's Tel No: Mobile No: 0522743500
Ins Card No: I019-010-119585478-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details: Temp36.7 B.P.122 Pulse. 86
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: M65.072 - Abscess of tendon sheath, left ankle and foot, R52 - Pain, unspecified

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

0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,85027, COMPLETE CBC AUTOMATED , Lab,9, Consultation Gp , General Consultation

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
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 27-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)