



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: 29-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2002-6932942-9
Card Holder's Name: SUJAL PARBAT Age: 22Y - 8M - 29D Sex: Male
Card Holder's Tel No: Mobile No: 554857889
Ins Card No: I005-010-120038783-01 Valid Upto: 30/9/2025
Company: FMC Standard Employee No: Nationality: Nepalese
Name: Network



Clinical Details: Temp 36.3 B.P. 98 Pulse. 76
Signs & Symptoms: RISK FOR FALL
Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
Diagnosis: R21 - Rash and other nonspecific skin eruption, T78.40XD - Allergy, unspecified, subsequent encounter

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

9, Consultation Gp , General Consultation

Doctor's Name: Dr.Farhan Iyas

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 29-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)