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: 30-Apr-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2004-4832169-3
Card Holder's Name: BIJOY SHIL Age: 20Y - 5M - 12D Sex: Male
Card Holder's Tel No: Mobile No: 0522460620
Ins Card No: I019-010-119176732-02 Valid Upto: 25/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Bangladeshi

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up v
Diagnosis: S61.011A - Laceration w/o fb of right thumb w/o damage to nail, init

Management plan (Services inside the clinic including injections and investigations)
51.01, Non-Surgical Cleansing With Surgical Dressing 16 Sq Inches / 100 Sq Centimeters Or Less , General Consultation,9, Consultat
General Consultation

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTI
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 an person who has provided medical services to me to furnish any and all information with regard to any medical history, medical cond medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 30-Apr-2025

Pharmaceuticals (to be filled by treating doctor only)