



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 FMC Standard Employee
Name: Network No: Nationality: Bangladeshi



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

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:

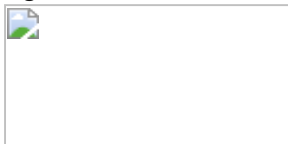
Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENT
DUBAI - U.A.E

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 conc 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)