



## ANNEXURE V

# F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842  
Email – [approval@fmchealthcare.ae](mailto:approval@fmchealthcare.ae) Helpline Number: 600-565691

### Medical Expenses Claim form

Date: 30-Apr-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1987-0974286-4

Card Holder's Name: MOUSTAFA MOHAMED YASSIN

Age: 38Y - 0M -

Sex: Male

Name: ABOUELMAGD

Age: 3D

Sex: Male

Card Holder's Tel No:

Mobile No:

0507279947

Ins Card No: I005-010-122064419-01

Valid Upto: 30/9/2025

Company Name: FMC Standard Network Employee No: \_\_\_\_\_ Nationality: Egyptian



Clinical Details:

Temp 37.6

B.P. 120

Pulse. 78

Signs & Symptoms: RISK FOR FALL

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up v

Diagnosis: R21 - Rash and other nonspecific skin eruption, R50.9 - Fever, unspecified, J02.9 - Acute pharyngitis, unspecified

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

85027, COMPLETE CBC AUTOMATED , Lab, 0195-107704-0802, CEFTRIAXONE-TABUK IM , Pharmacy, 0005-149902-1021, CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACE : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy, 9, Consultation Gp , General Consultation, 96372, THER/PROPH/DIAG INJ SC/IM Co.Pay, 96365, IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay

Doctor's Name: DR Amaizah

signature with seal:

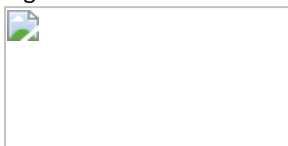
Dr. Amaizah Ishtiaq  
General Practitioner  
DHA: 98486553-001  
CITICARE MEDICAL CENT  
DUBAI - U.A.E

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 any person who has provided medical services to me to furnish any and all information with regard to any medical history, medical conditions, 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)