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

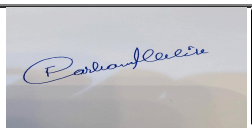
Date: 04-May-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-7150306-1
Card Holder's Name: TANVEER AHMAD Age: 27Y - 4M - 3D Sex: Male
Card Holder's Tel No: Mobile No: 566919855
Ins Card No: I020-010-117415414-04 Valid Upto: 27/4/2026
Company Name: FMC Standard Network Employee No: _____Nationality:Pakistani

Clinical Details:	Temp36	B.P.111	Pulse. 77
Signs & Symptoms: risk of fall			
Date of Onset Illness :		○ Emergency ○ Work related ○ New visit ○ Follow up visit	
Diagnosis: J30.9 - Allergic rhinitis, unspecified			

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 .Frahan 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 04-May-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	5	0.0000