

**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: 06-May-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-2003-3300207-7

Card Holder's Name: SIFEDDINE BENI HOUD

Age: 22Y - 1M - 15D Sex: Male

Card Holder's Tel No:

Mobile No:

0506753078

Ins Card No: I005-010-121967326-01

Valid Upto: 30/9/2025

Company FMC Standard

Employee

Name: Network

No:

Nationality: Moroccan



Clinical Details:

Temp 36.6

B.P. 130

Pulse: 88

Signs & Symptoms: RISK FPOR FALL

Date of Onset Illness :

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

Diagnosis: M54.5 - Low back pain, M62.830 - Muscle spasm of back, R52 - Pain, unspecified

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

0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 0005-149902-1021, CLOFEN , Pharmacy, 9, Consultation Gp , General Consultation

Doctor's Name: DR Amaizah

signature with seal:

Dr. Amaizah Ishtiaq
 General Practitioner
 DHA: 98486553-001
 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 06-May-2025



Pharmaceuticals (to be filled by treating doctor only)