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

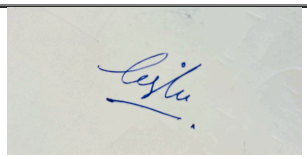
Date: 06-May-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-4084820-5
Card Holder's Name: SRIDHAR THOKALA THOKALA BHUMANNA Age: 25Y - 4M - 25D Sex: Male
Card Holder's Tel No: Mobile No: 0567915743
Ins Card No: I019-010-120074163-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp 36 B.P. 116 Pulse. 86
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow u
Diagnosis: R03.1 - Nonspecific low blood-pressure reading, H81.313 - Aural vertigo, bilateral, R53.1 - Weakness, R52 - Pain, unsp

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

0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 M
SOLUTION FOR INJECTION , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pa
Consultation Gp , General Consultation

Doctor's Name: AISHA signature with seal:



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 ab
mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or
person who has provided medical services to me to furnish any and all information with regard to any medical history, medical c
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)