



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: 07-May-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1997-3863102-9
Card Holder's UJWALA PANDURANG SHELKE Age: 28Y - 2M - Sex: Female
Name: PANDURANG DASHRATH SHELKE Age: 19D
Card Holder's Tel No: Mobile No: 0503449424
Ins Card No: 1005-010-117009982-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: Nationality: Indian



Clinical Details:	Temp 36.8	B.P. 120	Pulse. 80
Signs & Symptoms:	risk of fall		
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis: D50.9 - Iron deficiency anemia, unspecified, M62.81 - Muscle weakness (generalized), E86.0 - Dehydration, R03.1 - Nonspecific low blood-pressure reading, E55.9 - Vitamin D deficiency, unspecified, R42 - Dizziness and giddiness, R51.9 - Headache, unspecified			

Management plan (Services inside the clinic including injections and investigations)	
0439-152905-1001, LACTATED RINGERS INJECTION USP , Pharmacy, 96360, HYDRATION IV INFUSION INIT , Co.Pay, 85027, COMPLETE CBC AUTOMATED , Lab, 9, Consultation Gp , General Consultation	
Doctor's Name: DR Amaizah	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 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 07-May-2025



Pharmaceuticals (to be filled by treating doctor only)