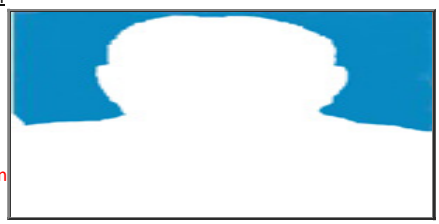
ANNEXURE V

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: 09-May-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1991-6693702-1
Card Holder's Name: RAJAB MABERI Age: 33Y - 6M - 14D Sex: Male
Card Holder's Tel No: Mobile No: 0581933015
Ins Card No: I005-010-121632954-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality:Ugandan

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: A01.00 - Typhoid fever, unspecified, R50.9 - Fever, unspecified, R10.84 - Generalized abdominal pain

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

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0005-149902-1021, CLOFEN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , 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 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 09-May-2025

Pharmaceuticals (to be filled by treating doctor only)