

**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 formDate: **11-May-2025**

Clinic Name: **CITICARE MEDICAL CENTER LLC** Emirates: **784-1977-3652195-2**
 Card Holder's Name: **MONICA MWIKALI MUNYAO** Age: **47Y - 9M - 14D** Sex: **Female**
 Card Holder's Tel No: Mobile No: **0543831977**
 Ins Card No: **I019-010-115341080-01** Valid Upto: **7/6/2025**
 Company Name: **FMC Standard Network** Employee No: _____ Nationality: **Kenyan**



Clinical Details: Temp **36.6** B.P. **154** Pulse. **79**
 Signs & Symptoms: **risk of fall**
 Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
 Diagnosis: **I10 - Essential (primary) hypertension**

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

9, Consultation Gp , General ConsultationDoctor's Name: **AISHA**

signature with seal:

Dr. Aisha Umer
 Physician- General Practitioner
 DHA- 40131439-002
 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 **11-May-2025**

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	TABLETS (30S, BLISTER)	30	30	0.0000