

**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: 14-May-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1993-9211792-7
 Card Holder's Name: Emmanuel Fynn Williams Age: 31Y - 7M - 29D Sex: Male
 Card Holder's Tel No: Mobile No: 0529764408
 Ins Card No: I005-010-121034053-01 Valid Upto: 30/9/2025
 Company: FMC Standard Employee No: _____ Nationality: Ghanaian
 Name: Network



Clinical Details: Temp 36.8 B.P. 140 Pulse. 62
 Signs & Symptoms: RISK FOR FALL
 Date of Onset Illness : _____
☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit
 Diagnosis: H57.10 - Ocular pain, unspecified eye, R52 - Pain, unspecified

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

9, Consultation Gp , General Consultation, 0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay

Doctor's Name: Dr.Farhan Iyas

signature with seal:

Dr .Farhan Ilyas Malik
 Physician-General Practitioner
 DHA-06441782-001
 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 14-May-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(IBUPROFEN : 400 MG) TABLETS	TABLETS (120S, BOX)	5	15	0.0000
(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	10	0.0000