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

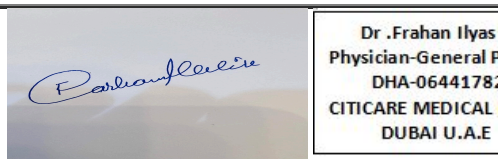
Date: 19-May-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-4242114-3
Card Holder's Name: AQIB JAVED MUHAMMAD JAVED Age: 27Y - 3M - 10D Sex: Male
Card Holder's Tel No: Mobile No: 0544052503
Ins Card No: I005-010-120643114-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Pakistani

Clinical Details: Temp 36.8 B.P. 128 Pulse. 85
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: G89.11 - Acute pain due to trauma, L03.032 - Cellulitis of left toe

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

51.01, Non-Surgical Cleansing With Surgical Dressing 16 Sq Inches / 100 Sq Centimeters Or Less , General Consultation

Doctor's Name: Dr.Farhan Iyas 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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 19-May-2025

Pharmaceuticals (to be filled by treating doctor only)