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

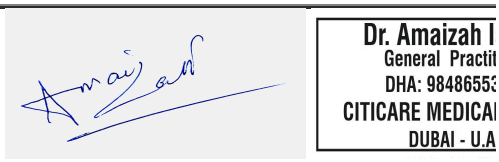
Date: 01-Jun-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-1880039-9
Card Holder's Name: ASHISH SINGH RANVEER SINGH Age: 25Y - 0M - 5D Sex: Male
Card Holder's Tel No: Mobile No: 0527927769
Ins Card No: I005-010-122568921-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: R21 - Rash and other nonspecific skin eruption

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

85027, COMPLETE CBC AUTOMATED , Lab,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Pharmacy,0125-12
DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , Genera
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 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 01-Jun-2025

Pharmaceuticals (to be filled by treating doctor only)