



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: 04-Jun-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 999-9999-9999999-9

Card Holder's Name: SUSHAT KUMAR

Age: 26Y - 6M - 3D Sex: Male

Card Holder's Tel No:

Mobile No:

0563233076

Ins Card No: I005-010-122774631-01

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 ☐ Follow up visit

Diagnosis: S81.811A - Laceration w/o foreign body, right lower leg, init encntr, R52 - Pain, unspecified

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

12001, RPR S/N/AX/GEN/TRNK 2.5CM/< , Co.Pay,9.01, Free Follow-Up Consultation Gp , General Consultation

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 04-Jun-2025

Pharmaceuticals (to be filled by treating doctor only)