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

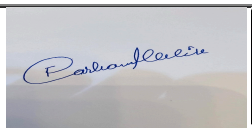
Medical Expenses Claim form

Date: 15-Jun-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-1068137-1
Card Holder's Name: ARAVINDA RUMESH NETHSARA ATHTHANAYAKE ATHTHANAYAKE MUDIYANSELAGE Age: 26Y - 8M - 22D Sex: Male
Card Holder's Tel No: Mobile No: 0561023776
Ins Card No: I005-010-121925253-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Sri Lankan

Clinical Details: Temp 36.8 B.P. 130 Pulse. 82
Signs & Symptoms: Risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: I83.893 - Varicose veins of bi low extrem w oth complications

Management plan (Services inside the clinic including injections and investigations)
9, Consultation Gp , General Consultation

Doctor's Name: Dr.Farhan Iyas signature with seal:



Dr .Frahan 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 15-Jun-2025

Pharmaceuticals (to be filled by treating doctor only)