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: 30-Jun-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-9518001-1
Card Holder's Name: DALIP SINGH UMESH SINGH Age: 30Y - 0M - 10D Sex: Male
Card Holder's Tel No: Mobile No: 0502052706
Ins Card No: I005-010-119293445-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.8 B.P.126 Pulse. 74
Signs & Symptoms:
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: M16.10 - Unilateral primary osteoarthritis, unspecified hip, M79.18 - Myalgia, other site

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

0005-149902-1021, CLOFEN , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: SANDIA signature with seal:

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
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 30-Jun-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity	Price
(IBUPROFEN : 600 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	7	21	0.0000