

**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:

Temp 36.8

B.P. 126

Pulse: 74

Signs & Symptoms:

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

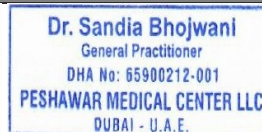
Diagnosis: M16.10 - Unilateral primary osteoarthritis, unspecified hip, M79.18 - Myalgia, other site

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:



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