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

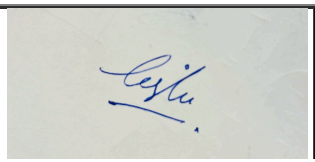
Date: 09-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-7363518-4
Card Holder's Name: BIKASH ROY BIJAY ROY Age: 30Y - 4M - 13D Sex: Male
Card Holder's Tel No: Mobile No: 0561531934
Ins Card No: I005-010-120488197-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36 B.P.128 Pulse. 92
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: N20.0 - Calculus of kidney, R30.0 - Dysuria, E86.0 - Dehydration

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

0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ
Co.Pay,0102-100104-1001, SODIUM CHLORIDE & DEXTROSE B.P. , Pharmacy,96360, HYDRATION IV INFUSION INIT , Co.Pay

Doctor's Name: AISHA signature with seal:



Dr. Aisha U
Physician- General P
DHA- 40131439
CITICARE MEDICA
DUBAI - U.A

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 09-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quantity
(SODIUM AESCINATE : 20 MG) TABLETS	TABLETS (40S, BOX)	5	10