



# ANNEXURE V

# F M C NETWORK UAE

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## Medical Expenses Claim form

Date: 13-Jul-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1998-4432506-0  
Card Holder's Name: SHAH ZEB MUHAMMAD AYAZ Age: 26Y - 8M - 17D Sex: Male  
Card Holder's Tel No: Mobile No: 0551900597  
Ins Card No: I019-010-122227736-02 Valid Upto: 7/6/2026  
Company: FMC Standard Employee No: Nationality: Pakistani  
Name: Network



|                         |                                                                                                                                          |          |           |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------|
| Clinical Details:       | Temp 36                                                                                                                                  | B.P. 145 | Pulse. 65 |
| Signs & Symptoms:       | RISK OF FALL                                                                                                                             |          |           |
| Date of Onset Illness : | <input type="radio"/> Emergency <input type="radio"/> Work related <input type="radio"/> New visit <input type="radio"/> Follow up visit |          |           |
| Diagnosis:              | S91.302A - Unspecified open wound, left foot, initial encounter                                                                          |          |           |

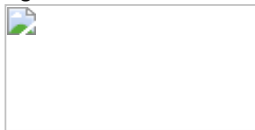
|                                                                                                                                   |                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| Management plan (Services inside the clinic including injections and investigations)                                              |                                                                                                          |
| 9, Consultation Gp , General Consultation                                                                                         |                                                                                                          |
| Doctor's Name: AISHA                                                                                                              | signature with seal:  |
| <div>Dr. Aisha Umer<br/>Physician- General Practitioner<br/>DHA- 40131439-002<br/>CITICARE MEDICAL CENTER<br/>DUBAI - U.A.E</div> |                                                                                                          |

|                                         |
|-----------------------------------------|
| 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 13-Jul-2025



Pharmaceuticals (to be filled by treating doctor only)