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: 16-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 999-9999-9999999-9
Card Holder's Name: RIMA DAS Age: 27Y - 5M - 12D Sex: Female
Card Holder's Tel No: Mobile No: +917001483430
Ins Card No: I019-010-123014015-01 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.6 B.P.126 Pulse. 96
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: R50.9 - Fever, unspecified, R52 - Pain, unspecified, R51.9 - Headache, unspecified, R07.0 - Pain in throat

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

0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION , Pharmacy,85027, COMPLETE CBC AUTOMATED , Lab,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: KEERTHANA signature with seal:

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مركز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

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 16-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)