



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:	Temp 36.6	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		

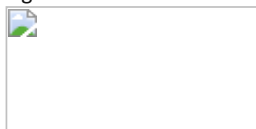
Management plan (Services inside the clinic including injections and investigations)	
0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy, 0005-111805-1021, CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION , Pharmacy, 85027, COMPLETE CBC AUTOMATED , Lab, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 9, Consultation Gp , General Consultation	
Doctor's Name: KEERTHANA	signature with seal: 
	

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)