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: 20-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1977-3652195-2
Card Holder's Name: MONICA MWIKALI MUNYAO Age: 47Y - 11M - 23D Sex: Female
Card Holder's Tel No: Mobile No: 0543831977
Ins Card No: I019-010-115341080-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Kenyan

Clinical Details: Temp 36.8 B.P. 146 Pulse. 72
Signs & Symptoms: risk of fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: I10 - Essential (primary) hypertension

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

9, Consultation Gp , General Consultation

Doctor's Name: KEERTHANA signature with seal:

راني باديبورايل ثارا
Dr. Keerthana Rani Padip
General Practi
License No.: 3786
CITICARE MEDICAL C

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 20-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(TELMISARTAN : 80 MG) TABLETS	TABLETS (28S, BLISTER PACK)	30	1
(AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (30S, BLISTER PACK)	30	30