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

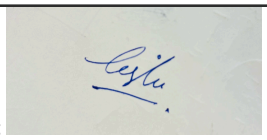
Date: 23-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-4986703-2
Card Holder's Name: MANOHAR MOROLLU MALLESH Age: 26Y - 0M - 9D Sex: Male
Card Holder's Tel No: Mobile No: +919182875582
Ins Card No: I005-010-120929338-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

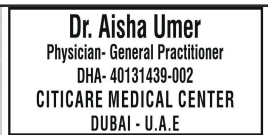
Clinical Details: Temp36.6 B.P.120 Pulse. 70
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: S91.312A - Laceration without foreign body, left foot, init encntr, S95.902A - Unsp inj unsp blood vess at ank/ft level, left leg, init

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

51.02, Non-Surgical Cleansing With Surgical Dressing Between 16 Sq Inches / 100 Sq Centimeters And 48 Sq Inches / 300 Sq Centimeters , General Consultation

Doctor's Name: AISHA 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 23-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)