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: 24-Jul-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2002-7613014-1
Card Holder's Name: PUJA ROY Age: 23Y - 2M - 12D Sex: Female
Card Holder's Tel No: Mobile No: 05445482315
Ins Card No: I005-010-122031303-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.8 B.P.90 Pulse. 66
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: H00.024 - Hordeolum internum left upper eyelid, R52 - Pain, unspecified

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 24-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quanti
(DEXAMETHASONE : 0.10%) (TOBRAMYCIN : 0.3%) EYE OINTMENT	EYE OINTMENT (3.5G, TUBE)	5	10
(LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	5	5