

**ANNEXURE V****F M C NETWORK UAE**

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
 Email – approval@fmchealthcare.ae Helpline Number: 600-562

Medical Expenses Claim form

Date: 30-Jul-2025

Clinic Name: CITICARE MEDICAL CENTER LLC

Emirates: 784-1996-3690952-7

Card Holder's Name: SOMEN PAUL

Age: 29Y - 5M - 23D

Sex: Male

Card Holder's Tel No:

Mobile No:

0582312762

Ins Card No: I019-010-120922157-02

Valid Upto: 7/6/2026

Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details:

Temp 36

B.P. 120

Pulse. 90

Signs & Symptoms: risk for fall

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit

Diagnosis: M54.5 - Low back pain, R52 - Pain, unspecified, M79.18 - Myalgia, other site, R25.2 - Cramp and spasm

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

0005-149902-1021, CLOFEN , Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co. Pay, 9, Consultation Gp , General C

Doctor's Name: Dr. Farhan Iyas

signature with seal:

 Dr.
 Physi
 Dr
 CITICAF
 D

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 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, F person who has provided medical services to me to furnish any and all information with regard to any medical histor medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 30-Jul-2025

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration
(NAPROXEN : 500 MG) TABLETS	TABLETS (10S, BLISTER PACK)	5
(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5

Medicine	Dose	Duration
(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (50G, TUBE)	5