



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

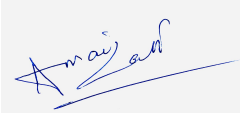
Medical Expenses Claim form

Date: 02-Aug-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1999-5977896-2
Card Holder's Name: RASHI BHATT BHAGYESH OMPRAKASH Age: 25Y - 8M - Sex: Female
BHATT Age: 25D
Card Holder's Tel No: Mobile No: 0563027548
Ins Card No: I005-010-121212090-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: Nationality: Indian



Clinical Details:	Temp 37.3	B.P. 130	Pulse. 84
Signs & Symptoms:	RISK OF FALL		
Date of Onset Illness :	☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit		
Diagnosis:	J03.90 - Acute tonsillitis, unspecified, R11.0 - Nausea, R50.9 - Fever, unspecified		

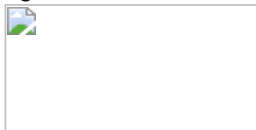
Management plan (Services inside the clinic including injections and investigations)	
85027, COMPLETE CBC AUTOMATED , Lab,86060, ANTISTREPTOLYSIN O TITER , Lab,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0046-111801-0511, (CHLORPHENIRAMINE : 10 MG) INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,9, Consultation Gp , General Consultation	
Doctor's Name: DR Amaizah	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 02-Aug-2025



Pharmaceuticals (to be filled by treating doctor only)