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

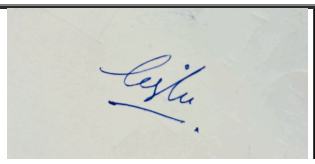
Date: 03-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2001-1290117-6
Card Holder's Name: MAREENA THISHUNI HIMASHA EDIRISINGHE Age: 23Y - 8M - 17D Sex:Female
Card Holder's Tel No: Mobile No: 0586687403
Ins Card No: I005-010-120365768-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____Nationality: Sri Lankan

Clinical Details: Temp36.4 B.P.102 Pulse. 88
Signs & Symptoms: RISK OF FALL
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: N91.2 - Amenorrhea, unspecified, I95.9 - Hypotension, unspecified, R52 - Pain, unspecified, E03.9 - Hypothyroidism

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

9, Consultation Gp , General Consultation

Doctor's Name: AISHA signature with seal:



Dr. Aisha U
Physician- General P
DHA- 40131439
CITICARE MEDICA
DUBAI - U.A

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 03-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)