

**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: 04-Aug-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-2585321-6

Card Holder's Name: SAJJAD ALI MUHAMMAD NIAZ Age: 30Y - 6M - 10D Sex: Male

Card Holder's Tel No: Mobile No: 0545329492

Ins Card No: I019-010-117080831-02 Valid Upto: 7/6/2026

Company FMC Standard Employee No: Nationality: Pakistani



Clinical Details: Temp 36 B.P. 110 Pulse: 60

Signs & Symptoms: risk of fall

Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

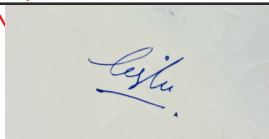
Diagnosis: J06.9 - Acute upper respiratory infection, unspecified, J30.9 - Allergic rhinitis, unspecified, R05 - Cough, M54.5 - Low back pain,
 R50.9 - Fever, unspecified, R07.0 - Pain in throat, I95.9 - Hypotension, unspecified

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

2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96374,
 THER/PROPH/DIAG INJ IV PUSH , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-149902-1021,
 CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,0384-
 111908-1001, SODIUM CHLORIDE B.P. , Pharmacy,96360, HYDRATION IV INFUSION

Doctor's Name: AISHA

signature with seal:



Dr. Aisha Umer
 Physician- General Practitioner
 DHA- 40131439-002
 CITICARE MEDICAL CENTER
 DUBAI - U.A.E

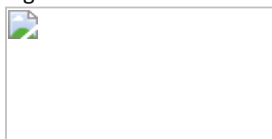
Diagnostic Procedures referred outside:

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 04-Aug-2025



Pharmaceuticals (to be filled by treating doctor only)