



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

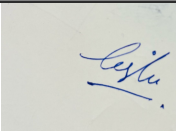
Medical Expenses Claim form

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
Name: Network



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			

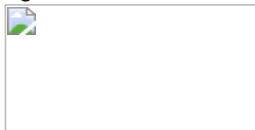
Management plan (Services inside the clinic including injections and investigations)	
2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION , Pharmacy,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-149902-1021, 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,96361, HYDRATE IV INFUSION A	
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)