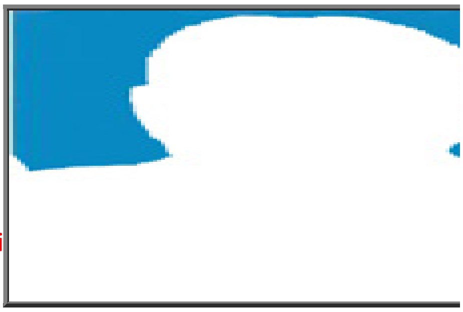
FMC NETWORK UAE
WE TAKE CARE OF YOU

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: 07-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-6906608-0
Card Holder's Name: ABRAR HASSAN NOOR HASSAN Age: 25Y - 5M - 1D Sex: Male
Card Holder's Tel No: Mobile No: 0529289701
Ins Card No: I019-010-121177972-02 Valid Upto: 7/6/2026
Company Name: FMC Standard Network Employee No: ________ Nationality: Pakistani

Clinical Details: Temp 37.3 B.P. 120 Pulse. 80
Signs & Symptoms: Risk of Fall
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: L08.9 - Local infection of the skin and subcutaneous tissue, unsp, R52 - Pain, unspecified, R50.9 - Fever, unspecified
Acute lymphadenitis of other sites, R22.41 - Localized swelling, mass and lump, right lower limb

Management plan (Services inside the clinic including injections and investigations)
51.02, Non-Surgical Cleansing With Surgical Dressing Between 16 Sq Inches / 100 Sq Centimeters And 48 Sq Inches / 300 Sq Ce
General Consultation,2190-106618-1001, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION ,
Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHAT
(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,96365, IV IN SION THERAPY/PROPHY
Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay

Doctor's Name: KEERTHANA signature with seal:

راني باديبورايل ثارا
Dr. Keerthana Rani Padipp
General Practit
License No.: 37864
يتيكير الطبي ذم م
CITICARE MEDICAL C

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 07-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)