

**ANNEXURE V****F M C NETWORK UAE**

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842  
 Email – [approval@fmchealthcare.ae](mailto:approval@fmchealthcare.ae) Helpline Number: 600-565691

Medical Expenses Claim formDate: **09-Aug-2025**Clinic Name: **CITICARE MEDICAL CENTER LLC**Emirates: **784-1995-5538336-5**Card Holder's Name: **JACQUELINE TABU OMAR** Age: **30Y - 2M - 21D** Sex: **Female**

Card Holder's Tel No:

Mobile No:

**0522702938**Ins Card No: **I019-010-118312395-02**

Valid Upto:

**7/6/2026**Company Name: **FMC Standard Network** Employee No: \_\_\_\_\_ Nationality: **Kenyan**

Clinical Details:

Temp **36.6**B.P. **100**Pulse. **68**Signs & Symptoms: **RISK FOR FALL**

Date of Onset Illness :

☐ Emergency ☐ Work related ☐ New visit ☐ Follow up visit

Diagnosis: **N64.4 - Mastodynia, L29.8 - Other pruritus, N63.0 - Unspecified lump in unspecified breast, N61.1 - Abscess of the breast and nipple**

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

**85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,9, Consultation Gp , General Consultation**Doctor's Name: **KEERTHANA**

signature with seal:



د. کیرثانا رانی پادیپورایل ثارا  
 Dr. Keerthana Rani Padippurayil Thara  
 General Practitioner  
 License No.: 37864046-001  
 مرکز سیتیکر الطبي ذم م  
 CITICARE MEDICAL CENTER LLC

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 **09-Aug-2025**

Pharmaceuticals (to be filled by treating doctor only)

| Medicine                                                                          | Dose                               | Duration | Quantity | Price  |
|-----------------------------------------------------------------------------------|------------------------------------|----------|----------|--------|
| (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS                     | FILM COATED TABLETS (12S, BLISTER) | 2        | 4        | 0.0000 |
| (CALAMINE : 10%) (VITAMIN E : 0.5%) (ALLANTOIN : 0.5%) (ALOE VERA : 10.5%) LOTION | LOTION (100ML, BOTTLE)             | 3        | 6        | 0.0000 |