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: 11-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-2000-6906608-0
Card Holder's Name: ABRAR HASSAN NOOR HASSAN Age: 25Y - 5M - 5D 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 B.P. Pulse.
Signs & Symptoms:
Date of Onset Illness :
○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: L08.9 - Local infection of the skin and subcutaneous tissue, unsp, R22.41 - Localized swelling, mass and lump, right lower limb

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

9.01, Free Follow-Up Consultation Gp , General Consultation,51.02, Non-Surgical Cleansing With Surgical Dressing Between 16 Sq Inches / 100 Sq Centimeters And 48 Sq Inches / 300 Sq Centimeters , General Consultation

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 11-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)