



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: 14-Aug-2025

Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1995-8385436-1

Card Holder's Name: MUHAMMAD ISLAM KHAN DAD Age: 30Y - 5M - 0D Sex: Male

Card Holder's Tel No: Mobile No: 0556629295

Ins Card No: I005-010-119843963-01 Valid Upto: 30/9/2025

Company: FMC Standard Employee: Nationality: Pakistani
Name: Network No:



Clinical Details: Temp 36.4 B.P. 120 Pulse. 64
Signs & Symptoms: risk of fall
Date of Onset Illness : ☐ Emergency ☐ Work related ☐ New visit ☐ Follow
Diagnosis: J03.91 - Acute recurrent tonsillitis, unspecified, R52 - Pain, unspecified, R50.9 - Fever, unspecified, R06.2 - Wheezin
Cough variant asthma

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

85027, COMPLETE CBC AUTOMATED , Lab, 0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4
SOLUTION FOR INJECTION , Pharmacy, 94640, AIRWAY INHALATION TREATMENT , Co.Pay, 0188-135906-2441, PULMICORT ,
Pharmacy, 96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay, 9, Consultation Gp , General Consultation

Doctor's Name: DR Amaizah

signature with seal:

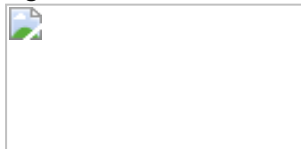
Dr. Amaizah I
General Practitioner
DHA: 98486553
CITICARE MEDICAL
DUBAI - U.A.E

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 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, medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 14-Aug-2025



Pharmaceuticals (to be filled by treating doctor only)