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: 10-Feb-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-8340056-0
Card Holder's Name: SAWARAN CHAND Age: 28Y - 6M - 9D Sex: Female
Card Holder's Tel No: 971589522956 Mobile No: 0589522956
Ins Card No: I005-010-117490735-01 Valid Upto: 30/9/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36.8 B.P.130 Pulse. 76
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follow up visit
Diagnosis: R21 - Rash and other nonspecific skin eruption, T78.40XA - Allergy, unspecified, initial encounter

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

82785, ASSAY OF IGE , Lab,85025, COMPLETE CBC W/AUTO DIFF WBC , Lab,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE , Pharmacy,0005-111805-1021, CHLOROHISTOL 10MG , Pharmacy,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,9, Consultation Gp , General Consultation

Doctor's Name: DR Amaizah signature with seal:

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
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 10-Feb-2025

Pharmaceuticals (to be filled by treating doctor only)