



1. HealthNet Policy Number

1038-000-
115399051-01

2. Patient Name

2. Authorization
Code:
KAILASH DAGDE DEVANNA DAGDE

3. Patient Date of Birth & Sex

06-07-98(dd/mm/yy) ☒ Male ☐
Female

5. Nature of illness or Injury

Mobile No. 0556708489

6. Are You the patient's primary physician

☐ Acute ☐ Chronic ☐ Emergency
☐ Yes ☐ No

7. Presenting Complaints: Recurrent papular lesions on the forehead.

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acne vulgaris, Pseudofolliculitis barbae

ICD Code L70.0, L73.1

12. Etiology:

13. In case of Injury: mode of Injury/place of Injury

14. Plan / Details of Management

a. **Procedure** Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

CPT code 9

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

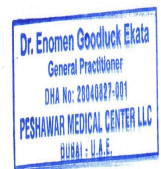
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0138-169101-1452	(DOXYCYCLINE : 100 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (500S, BLISTER PACK)	30	Take 1 Capsule 1 Time(s) per Day For 30 Day(s) others
0080-109601-0431	(BENZOYL PEROXIDE : 10%) GEL	GEL (50G, TUBE)	30	Take 1 Gel 2 Time(s) per Day For 30 Day(s) others

Date: 07-06-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp



Physician Code DHA-P-28040827 HNM Code

Authorization

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 Hospital, Physician, Pharmacy or any other person who has provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medical condition or medical services and copies of all medical and hospital records.

A Photocopy or teletax copy of this authorization shall be considered effective any valid as the original

Date: 07-06-24(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)

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