



1.HealthNet Policy Number

I038-000-
120086838-01

2.
Authorization
Code:

2.Patient Name

WISHWA LAVAN HEENATIGALA

3.Patient Date of Birth & Sex

01-11-00(dd/mm/yy)

☒ Male ☐
Female

5.Nature of illness or Injury

Mobile No.0558740635

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

Represented still has Pain in the left ear

Duration/onset: 31/05/2024 (11 days)

pain comes on upon opening the mouth

Exam of the Ears were normal.

Dental examination also normal

TMJ arthritis suspected.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Other otitis externa, left ear, Otagia, left ear

ICD Code H60.8X2, H92.02

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureOffice 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 patients and/or families 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 code9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

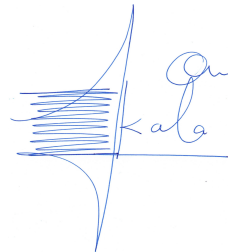
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) after meal
0355-103204-1681	(CIPROFLOXACIN : 0.3%) EYE / EAR DROPS	EYE / EAR DROPS (5ML, PLASTIC DROPPER BOTTLE)	7	Take 2Tablets 4 Time(s) per Day For 7 Day(s) others

Date: 10-06-24(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: 10-06-24(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

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

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