



1. HealthNet Policy Number

I038-000-117253227-01

2. Authorization Code:

2. Patient Name

IHSSANE YAALA

3. Patient Date of Birth & Sex

07-11-98(dd/mm/yy)

☐ Male ☒ Female

Mobile No. 0501543860

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

PC; Pain in the throat.

Duration: 7 days.

worst on swallowing, there is no fever.

Has been on medications for flu but no respite

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acute tonsillitis, unspecified, Pain in throat, Fever, unspecified

ICD Code J03.90, R07.0, R50.9

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: GP repeat visit for OP Consultation refers to week 2, 3 & 4 from the date of initial consultation for same illness in OPD.

CPT code 9.02

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

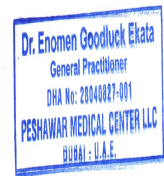
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	3	Take 1 Tablets 2 Time(s) per Day For 3 Day(s) after meal
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	TABLETS (20S, BLISTER PACK)	5	Take 1 Tablets 1 Time(s) per Day For 5 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	10	Take 1 Tablets 2 Time(s) per Day For 10 Day(s) after meal

Date: 21-06-24(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: 21-06-24(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

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

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