1.HealthNet Policy Number	I038-000-114321432-01	2. Authorization Code:
2.Patient Name	Nasurudin Batuma	
3.Patient Date of Birth & Sex	02-02-90(dd/mm/yy)	☑ Male ☐ Female
	Mobile No.0529576739	
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency	
6.Are You the patient's primary physician	☐ Yes ☐ No	
7.Presenting Complaints:		
PC: FUNGAL INFECTION AT FEET		
ITCHING 1 DAY		
8.Duration of Symptoms:		
9.Onset of Condition:		
10.Relevent Past Medical/Surfgical History		
DiagonosisiMycosis fungoides, unspecified site, Allergic contact dermatitis, unspecified cause	ICD Code C84.00, L23.9	
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 familys 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., (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,Intramuscular injection	CPT code9,0125-122107-1022,96372	

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0027-109206-0151	(TERBINAFINE (AS HCL) : 1%) CREAM	CREAM (15G, TUBE)	7	Take 1Cream 2 Time(s) per Day For 7 Day(s) others
0195-123701-0391	CETIRIZINE HCL	Tablet	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening

Date: 27-07-24(dd/mm/yy)

Signature and Stamp

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Doctor's Name Enomen Goodluck

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: 27-07-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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