



1.HealthNet Policy Number	I038-000-119490867-01	2. Authorization Code:
2.Patient Name	EDRINE MIIRO	
3.Patient Date of Birth & Sex	07-10-00(dd/mm/yy)	☒ Male ☐ Female
5.Nature of illness or Injury	Mobile No.971508090199	
6.Are You the patient's primary physician	☐ Acute ☐ Chronic ☐ Emergency	
7.Presenting Complaints:	☐ Yes ☐ No	
Injury to the lower lip.		
Said to have been swimming when he hit his mouth against the swimming pool wall.		
8.Duration of Symptoms:		
9.Onset of Condition:		
10.Relevant Past Medical/Surgical History		
DiagnosisLaceration without foreign body of lip, initial encounter, Acute pain due to trauma		ICD Code S01.511A, G89.11
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.		
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
	0067-142201-0392	(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) after meal

Date: 07-08-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp



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

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: 07-08-24(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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