



1. HealthNet Policy Number 2. I038-000-115298135-01 Authorization Code:
2. Patient Name IKECHUKWU VICTOR NDUCHE
3. Patient Date of Birth & Sex 13-09-85(dd/mm/yy) ☒ Male ☐ Female
5. Nature of illness or Injury Mobile No. 0555891985
6. Are You the patient's primary physician ☐ Acute ☐ Chronic ☐ Emergency
7. Presenting Complaints: ☐ Yes ☐ No

PC: MEDICATION REFILL

DEHYDRATION

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Essential (primary) hypertension, Hyperlipidemia, unspecified

ICD Code I10, E78.5

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:

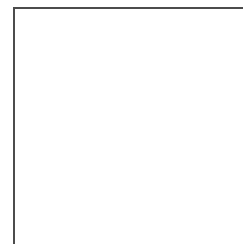
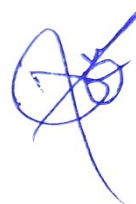
Date of Discharge:

16. PRESCRIPTION WITH DOSAGE & DURATION				
Code	Generic	Dosage	Duration	Instructions
0042-442201-1171	(TELMISARTAN : 80 MG) (AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	TABLETS (28S, BLISTER PACK)	60	Take 1 Tablet 1 Time(s) per Day For 60 Day(s) others
2138-386002-0391	(ATORVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER)	60	Take 1 Tablet 1 Time(s) per Day For 60 Day(s) others

Date: 10-08-24(dd/mm/yy)

Doctor's Name AHSAN HUSSAIN

Signature and Stamp



Physician Code DHA-P-87543658 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: 10-08-24(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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