

| 1.HealthNet Policy Number | | | | 1038-000-119490855-01 2. Authorization Code: | | | | | | |
|---|--|--|-----------------|--|------------|------------------|-----------------|-----------------------------|--|--|
| 2.Pa | atient Name | | | | ROJEAN PE | ESCADOR ELIZAR | lO | | | |
| | 3.Patient Date of Birth & Sex | | | | 12-09-72(| dd/mm/yy) | | ☐ Male ✓ Female | | |
| | | | | | | 0.0522363835 | | | | |
| 5.N | ature of illness or | r Iniurv | | | | ☐ Chronic ☐ | Emerger | ICV | | |
| 6.Are You the patient's primary physician | | | | | ☐ Yes ☐ No | | | | | |
| 7. Presenting Complaints: | | | | | | | | | | |
| ' ' ' | reserring comple | | | | | | | | | |
| For | routine medical | checkup. | | | | | | | | |
| A kı | nown hyperthyro | id patient and had t | hyroidectomy | 2 years ago. | | | | | | |
| Also | Also being managed for hypercholesterolemia. | | | | | | | | | |
| Has | Has family history of DM, renal failure and type 2 diabetes. | | | | | | | | | |
| 8.D | 8.Duration of Symptoms: | | | | | | | | | |
| 9.0 | nset of Condition | ı: | | | | | | | | |
| 10. | Relevent Past Me | dical/Surfgical Histo | ry | | | | | | | |
| | • | iidism, unspecified, Hyp nspecified, Nocturia, Fa | | • | ICD Code | E03.9, E78.5, E5 | 55.9, R35.: | 1, Z83.3, R73.9 | | |
| | litus, Hyperglycemia | | , , | | | , , | , | . , | | |
| 12. | Etiology: | | | | | | | | | |
| 13. | In case of Injury:r | mode of Injury/place | e of Injury | | | | | | | |
| 14. | Plan / Details of N | Management | | | | | | | | |
| | | d Count Complete Auto | | | | | | | | |
| Count, Lipid Panel, Hemoglobin Glycosylated A1C, Creatinine CPT code85025,80061,83036,82565,80076,80051,9 Blood, Hepatic Function Panel, Electrolyte Panel, Gp Consultation | | | | | | | 5,80076,80051,9 | | | |
| | b.Laboratiry Test: | ction Fanel, Liectrolyte | ranei, ap consu | itation | | | | | | |
| | | ostigations: | | | | | | | | |
| | c.Radiology / Inv | estigations. alization: Date of Ad | dmissions | | Date of C | ischarge: | | | | |
| 16. | · | alization. Date of Au | | | | | | | | |
| 10. | | | | ON WITH DOSA | | | | | | |
| | Code | Generic | Dosage | D | uration | | Instructio | ns | | |
| | No Prescriptions I | History Found | | | | | | | | |
| Dat | te· | 19-08-24(dd/mn | n/vv) | | | | | Dr. Enomen Goodluck Ekata | | |
| | | 25 66 2 1(00) 1111 | , , , , , | | | | Ju . | General Practitioner | | |
| | | | | Signature and | d Stamp | * Eka | (g , | DHA No: 28040827-001 | | |
| Doctor's Name Enomen Goodluck | | | | | | | | CITICARE MEDICAL CENTER LLC | | |
| Phy | ysician Code DHA | ∿-P-28040827 HNM C | Code | | | | | DUBAI - U.A.E. | | |
| ' | | | | | | | | | | |
| Aut | horization | | | | | | | | | |

1 of 2 8/19/2024, 9:34 PM

| 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 autho | rization shall be considered effective any valid as the orig | ginal | | | | | | |
| Date: 19-08-24(dd/mm/yy) | Signature of Insued / Claimint | | | | | | | |

Copy of NGI - Pharmacy



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

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2 of 2 8/19/2024, 9:34 PM