1.HealthNet Policy Number I038-000-118518723-01 2. Authorizatio Code:

2.Patient Name ALANA WALLACE

3.Patient Date of Birth & Sex 20-07-88(dd/mm/yy) ☐ M Fema

Mobile No.+447870880826

5.Nature of illness or Injury ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician ☐ Yes ☐ No

7.Presenting Complaints:

history of endometriosis and marina

co breast lump left side june 2024

oe

left side one lump but it difuse in nature

chest is clear

axillary lymph nodes not enlarge

no previous histoy of any lump breast

stable

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

Diagonosisi Unspecified lump in the left breast, upper inner quadrant ICD Code N63.22

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 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. CPT code 9

b.Laboratiry Test:

c.Radiology / Investigations:

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

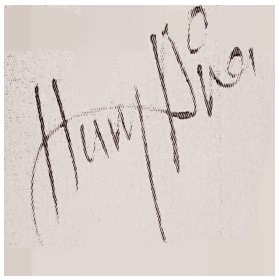
16.

**PRESCRIPTION WITH DOSAGE & DURATION**

| Code | Generic | Dosage | Duration | Instructions |
|---|---|---|---|---|
| No Prescriptions History Found | | | | |

Date: 23-08-24(dd/mm/yy)

Signature and Stamp




Doctor's Name Humaira

Physician Code DHA-P-54155530 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 me examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other per provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medi 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: 23-08-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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