



1. HealthNet Policy Number	I038-000-121036440-01	2. Authorization Code:		
2. Patient Name	ERIC MUTHIANI MWANZIA			
3. Patient Date of Birth & Sex	29-08-00(dd/mm/yy)	☒ Male ☐ Female		
5. Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency			
6. Are You the patient's primary physician	☐ Yes ☐ No			
7. Presenting Complaints:				
PC: MUSCLE PAIN WEAKNESS				
8. Duration of Symptoms:				
9. Onset of Condition:				
10. Relevant Past Medical/Surgical History				
Diagnosis: Muscle weakness (generalized), Low back pain		ICD Code M62.81, M54.5		
12. Etiology:				
13. In case of Injury: mode of Injury/place of Injury				
14. Plan / Details of Management				
a. Procedure: CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION, Intramuscular injection, 9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000) CPT code 0005-149902-1021, 96372, 9.01				
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
BN10X4.5	BANDAGE LONG (10CM X 4.5 CM)		1	Take 1 Units 1 Time(s) per Day For 1 Day(s) after meal
0278-107902-0391	IBUPROFEN	Tablet	7	Take 1 Tablets 2 Time(s) per Day For 7 Day(s) after meal
Date: 26-08-24(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: 26-08-24(dd/mm/yy)		Signature of Insured / Claimant		

