



1.HealthNet Policy Number

I038-000-
118180002-012.
Authorization
Code:

2.Patient Name

WAQAR AHMAD BUTT SHOAIB AHMAD
BUTT

3.Patient Date of Birth & Sex

16-09-97(dd/mm/yy)

☒ Male ☐
Female

5.Nature of illness or Injury

Mobile No.0544710556

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

PC:Skin macular and also fungi lesion in all over the body

DANDRUFF ON HEAD

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Mycosis fungoides, unspecified site, Allergic contact dermatitis, unspecified
cause

ICD Code C84.00, L23.9

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 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.

CPT code 9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

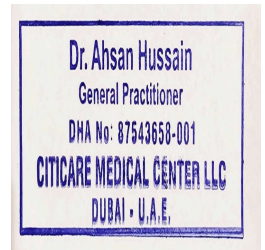
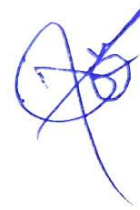
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0252-140201-0061	(FLUCONAZOLE : 150 MG) CAPSULES	CAPSULES (1S, BLISTER PACK)	5	Take 1 Tablets 1 Time(s) per Week For 5 Day(s) after meal
0006-131401-2261	(BETAMETHASONE : 0.1%) SCALP SOLUTION	SCALP SOLUTION (30ML, BOTTLE)	7	Take 1 Lotion 2 Time(s) per Day For 7 Day(s) others

Date: 28-08-24(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: 28-08-24(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

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

NGI House Building, P.O. Box 154, Deira, Dubai, Tel: +971 4 211 5800, Fax: +971 4 250 2854, Email: ngico@emirates.net.ae, Website: www.ngi.ae

