1.HealthNet Policy Number I038-000-121234278-01 2. Authorization Code:

2.Patient Name Kaung Wai Yan

3.Patient Date of Birth & Sex 02-10-98(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0523163590

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

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

7.Presenting Complaints:

PC: pain in feet

gout patient known

low back pain

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiPain in right foot, Low back pain, Muscle spasm of back ICD Code M79.671, M54.5, M62.830

12.Etiology:

13.In case of Injury:mode of Injury/place of Injury

14.Plan / Details of Management

a.ProcedureCLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,Intramuscular injection,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 code0005-149902-1021,96372,9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

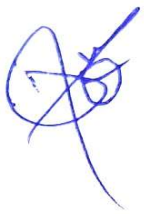
PRESCRIPTION WITH DOSAGE & DURATION

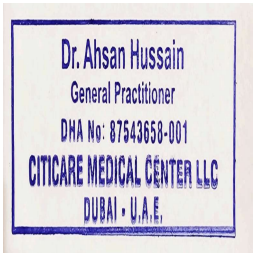
Code	Generic	Dosage	Duration	Instructions
0278-107902-0391	(IBUPROFEN : 400 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
0207-112401-1171	(ALLOPURINOL : 100 MG) TABLETS	TABLETS (100S, BLISTER PACK)	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) evening

Date: 17-10-24(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: 17-10-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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HealthNet