



1.HealthNet Policy Number

I038-000-  
120086839-012.  
Authorization  
Code:

2.Patient Name

W MUDIYANSELAGE KANISHKA  
NILUPUL WICKRAMASIGHE

3.Patient Date of Birth &amp; Sex

04-12-97(dd/mm/yy)

☒ Male ☐  
Female

Mobile No.0542982776

5.Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

pc: fever

flu

runny nose

low back pain

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Acute upper respiratory infection, unspecified, Acute nasopharyngitis  
[common cold], Acute bronchitis, unspecified, Low back pain, Cough

ICD Code J06.9, J00, J20.9, M54.5, R05

12.Etiology:

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

14.Plan / Details of Management

a.Procedure: TRIAXONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, DEXAMETHASONE SODIUM PHOSPHATE, nebulization with ventoline solution, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, Administered intravenously, Intramuscular injection, Blood Count Manual Cell Count Each, C-Reactive Protein, 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 0005-107704-0802, 2190-106618-1001, 0125-122107-1022, 94640, 0188-135906-2441, 96365, 96372, 85032, 86140, 9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

## PRESCRIPTION WITH DOSAGE &amp; DURATION

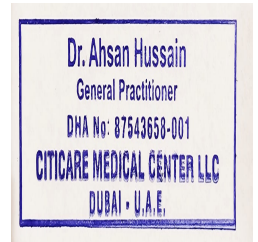
| Code             | Generic                                                                                              | Dosage                                  | Duration | Instructions                                              |
|------------------|------------------------------------------------------------------------------------------------------|-----------------------------------------|----------|-----------------------------------------------------------|
| 0027-265802-1161 | (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP                                                    | SYRUP (200ML, BOTTLE)                   | 7        | Take 5 ml Syrup 2 Time(s) per Day For 7 Day(s) after meal |
| 0252-185801-0391 | (DIPHENHYDRAMINE : 25 MG)<br>(PARACETAMOL : 500 MG)<br>(PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS | FILM COATED TABLETS (20S, BLISTER PACK) | 7        | Take 1 Tablets 2 Time(s) per Day For 7 Day(s) after meal  |

| Code             | Generic                                                      | Dosage                                        | Duration | Instructions                                                |
|------------------|--------------------------------------------------------------|-----------------------------------------------|----------|-------------------------------------------------------------|
| 0139-116206-1171 | (CLAVULANIC ACID : 125 MG)<br>(AMOXICILLIN : 875 MG) TABLETS | TABLETS (14S,<br>BLISTER PACK)                | 7        | Take 1Tablets 2Time(s)<br>perDay For 7 Day(s)<br>after meal |
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED<br>TABLETS              | FILM COATED<br>TABLETS (10S,<br>BLISTER PACK) | 5        | Take 1Tablets 1 Time(s)<br>per Day For 5 Day(s)<br>others   |

Date: 26-10-24(dd/mm/yy)

Doctor's Name AHSAN HUSSAIN

Signature and Stamp

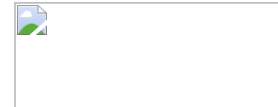



Physician Code DHA-P-87543658 HNM Code

**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: 26-10-24(dd/mm/yy)

Signature of Insured / Claimant

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

