1.HealthNet Policy Number I038-000-116927662-01 2. Authorization Code:

2.Patient Name GENE MICHAEL ZABALLERO ARRIETA

3.Patient Date of Birth & Sex 28-05-90(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0501961139

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

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

7.Presenting Complaints:

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute upper respiratory infection, unspecified, Urinary tract infection, site not specified, Fever, unspecified, Cough, Acute gastritis without bleeding

ICD Code J06.9, N39.0, R50.9, R05, K29.00

12.Etiology:

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

14.Plan / Details of Management

a.Procedure9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000),nebulization with ventoline solution,PULMICORT, (PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,CEFTRIAXONE-TABUK IV,Administered intravenously,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000)

CPT code9.01,94640,0188-135906-2441,0005-242802-0781,0195-107704-0801

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission:

Date of Discharge:

16.

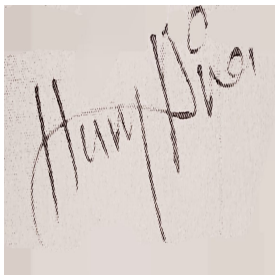
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
No Prescriptions History Found				

Date: 30-10-24(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



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: 30-10-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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