



1.HealthNet Policy Number

I038-000-

117559457-01

2. Authorization

Code:

2.Patient Name

SARAN SATHEESH KUMAR SATHEESH  
KUMAR CHIRACKAL BHASKARAN  
ACHARY

3.Patient Date of Birth &amp; Sex

17-02-99(dd/mm/yy)

☒ Male ☐

Female

5.Nature of illness or Injury

Mobile No.0525513810

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

co headache 13th nov. 2024

oe chest is clear no added sounds

restless

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis Elevated blood-pressure reading, w/o diagnosis of htn

ICD Code R03.0

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureGENERAL WELNES CHECKUP ( 55 TEST),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 code101,9

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 |
|--------------------------------|---------|--------|----------|--------------|
| No Prescriptions History Found |         |        |          |              |

Date: 15-11-24(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp

Dr. Humaira Mumtaz  
General Practitioner  
DHA No: 54155530-002  
CITICARE MEDICAL CENTER LLC  
DUBAI - U.A.E.

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 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: 15-11-24(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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