1.HealthNet Policy Number I038-000-121569467-01 2. Authorization Code:

2.Patient Name NAVEEN TIWARI MURARI LAL TIWARI

3.Patient Date of Birth & Sex 07-06-95(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0564502817

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

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

7.Presenting Complaints:

pc: nausea with vomiting 12/12/2024

weakness

dehydration

epigastric pain

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiNausea with vomiting, unspecified, Epigastric pain, Acute gastritis without bleeding, Low back pain, Dehydration ICD Code R11.2, R10.13, K29.00, M54.5, E86.0

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureLACTATED RINGERS INJECTION USP,PREMOSAN ,SCOPINAL,RISEK 40MG,Administered intravenously,Intramuscular injection,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000) CPT code0102-152902-1001,0005-150403-1021,0005-136504-1021,0005-174202-0781,96365,96372,9.01

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
0005-150407-1172	(METOCLOPRAMIDE : 10 MG TABLETS	TABLETS (20S, BLISTER PACK	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) before meal
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	CAPSULES (HARD GELATIN (14S, BLISTER	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) before meal
0005-136501-0393	(HYOSCINE : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others

Date: 12-12-24(dd/mm/yy)

Doctor's Name AHSAN HUSSAIN

Signature and Stamp

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

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: 12-12-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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HealthNet