1.HealthNet Policy Number I038-000-120236408-01 2. Authorization Code:

2.Patient Name SHAHZAD AHMED MUHAMMAD MUSHTAQ

3.Patient Date of Birth & Sex 04-09-90(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0561621787

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 gastritis without bleeding, Elevated blood-pressure reading, w/o diagnosis of htn ICD Code K29.00, R03.0

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureLipid Panel,Renal Function Panel,PANTONIX 40MG I.V.,Administered intravenously,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000) CPT code80061,80069,0005-242802-0781,96365,9.01

b.Laboratiry Test:

c.Radiology / Investigations:

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

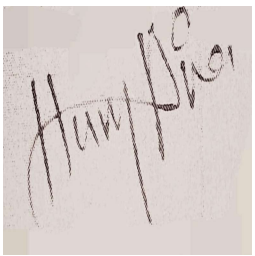
16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
1267-141614-1112	(ALUMINIUM HYDROXIDE : 225 MG/5ML (SIMETHICONE : 25 MG/5 ML (MAGNESIUM HYDROXIDE : 200 MG/5ML SUSPENSION	SUSPENSION (180ML, PLASTIC BOTTLE	1	Take 10 ml 3 times in a day
0195-116604-0391	(METRONIDAZOLE : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0195-148602-0391	(CLARITHROMYCIN : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (14S, BLISTER PACK	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others

Date: 03-01-25(dd/mm/yy)

Signature and Stamp



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

Doctor's Name Humaira

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: 03-01-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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