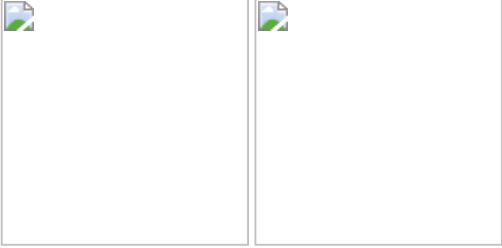




1.HealthNet Policy Number	I038-000-113198349-01	2. Authorization Code:															
2.Patient Name	TATSIANA RAMANENIA																
3.Patient Date of Birth & Sex	11-07-88(dd/mm/yy)	☐ Male ☒ Female															
5.Nature of illness or Injury	Mobile No.971567459909																
6.Are You the patient's primary physician	☐ Acute ☐ Chronic ☐ Emergency																
7.Presenting Complaints:	☐ Yes ☐ No																
8.Duration of Symptoms:																	
9.Onset of Condition:																	
10.Relevant Past Medical/Surgical History																	
Diagnosis	Burns involving less than 10% of body surface, Acute pain due to trauma, Cellulitis of left upper limb																
12.Etiology:	ICD Code T31.0, G89.11, L03.114																
13.In case of Injury:mode of Injury/place of Injury																	
14.Plan / Details of Management																	
a.Procedure	NON-SURGICAL CLEANSING WITH SURGICAL DRESSING MORE THAN 48 SQ INCHES / 300 SQ CENTIMETERS.,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000)																
b.Laboratory Test:	CPT code51.03,9.01																
c.Radiology / Investigations:																	
15.In Case of Hospitalization: Date of Admission:	Date of Discharge:																
16.	<table><tr><th colspan="5">PRESCRIPTION WITH DOSAGE & DURATION</th></tr><tr><th>Code</th><th>Generic</th><th>Dosage</th><th>Duration</th><th>Instructions</th></tr><tr><td colspan="5">No Prescriptions History Found</td></tr></table>		PRESCRIPTION WITH DOSAGE & DURATION					Code	Generic	Dosage	Duration	Instructions	No Prescriptions History Found				
PRESCRIPTION WITH DOSAGE & DURATION																	
Code	Generic	Dosage	Duration	Instructions													
No Prescriptions History Found																	
Date:	11-01-25(dd/mm/yy)																
Doctor's Name	DR Amaizah																
Physician Code	DHA-P-98486553-001	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:	11-01-25(dd/mm/yy)	Signature of Insured / Claimint															

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

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