1.HealthNet Policy Number I038-000-115399051-01 2. Authorization Code:

2.Patient Name KAILASH DAGDE DEVANNA DAGDE

3.Patient Date of Birth & Sex 06-07-98(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0556708489

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

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

7.Presenting Complaints:

pc : pain and swelling lft toe

no itching ,no fever

o/e hyperkeratosis of palmar aspect of big toe, pressure sore ,(grade 1 ulcer)

counselled for need of debridement on next visit

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiRash and other nonspecific skin eruption, Pain in left toe(s) ICD Code R21, M79.675

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureOffice 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 familys 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 code9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

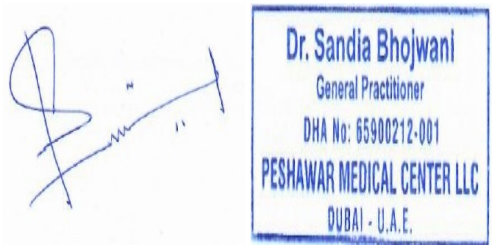
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0252-149801-0151	(CLOBETASOL PROPIONATE : 0.05% CREAM	CREAM (25G, COLLAPSIBLE TUBE	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0005-119805-1174	(PREDNISOLONE : 5 MG TABLETS	TABLETS (40S, BLISTER	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0009-101701-1171	(ACECLOFENAC : 100 MG TABLETS	TABLETS (20S, BLISTER PACK	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

Date: 13-01-25(dd/mm/yy)

Doctor's Name SANDIA

Signature and Stamp



Physician Code DHA-P-65900212 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: 13-01-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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