



1. HealthNet Policy Number	I038-000-120411689-01	2. Authorization Code:
2. Patient Name	ADITYA SHAHI	
3. Patient Date of Birth & Sex	16-08-93(dd/mm/yy)	☒ Male ☐ Female
5. Nature of illness or Injury	Mobile No. 0509089651	
6. Are You the patient's primary physician	☐ Acute ☐ Chronic ☐ Emergency	
7. Presenting Complaints:	☐ Yes ☐ No	
pain in right lower rib due to dumble fall in gym		
o/e there is minor swelling in lower ribs		
8. Duration of Symptoms:		
9. Onset of Condition:		
10. Relevant Past Medical/Surgical History		
Diagnosis: Fever, unspecified	ICD Code R50.9	
12. Etiology:		
13. In case of Injury: mode of Injury/place of Injury		
14. Plan / Details of Management		
a. Procedure: CLOFEN, Intramuscular injection, 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 patient's and/or family's 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 code 0005-149902-1021, 96372, 9	

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

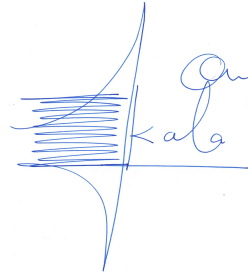
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0027-378802-0433	(DICLOFENAC SODIUM (AS DIETHYLAMINE) : 10 MG/G) GEL	GEL (75G, DISPENSER)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0031-149904-1171	(DICLOFENAC SODIUM : 50 MG TABLETS	TABLETS (20S, BLISTER PACK	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
4884-622202-1171	(SERRAPEPTASE : 10 MG TABLETS	TABLETS (30S, BLISTER	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others

Date: 15-01-25(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp



Physician Code DHA-P-28040827 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: 15-01-25(dd/mm/yy)

Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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