



1.HealthNet Policy Number	I038-000-117669244-01	2. Authorization Code:
2.Patient Name	UZAIR AHMED RAJA AFTAB RAZA	
3.Patient Date of Birth & Sex	23-09-01(dd/mm/yy)	☒ Male ☐ Female
	Mobile No.0561857571	
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency	
6.Are You the patient's primary physician	☐ Yes ☐ No	
7.Presenting Complaints:		
pc : cough which is dry , watery eyes , headache for 10 days associated with low grade fever		
o/e hyperemia of pharynx		
chest congested		
8.Duration of Symptoms:		
9.Onset of Condition:		
10.Relevent Past Medical/Surfgical History		
Diagonosisi	Acute pharyngitis, unspecified, Acute upper respiratory infection, unspecified, Fever, unspecified	
	ICD Code J02.9, J06.9, R50.9	
12.Etiology:		
13.In case of Injury:mode of Injury/place of Injury		
14.Plan / Details of Management		
a.Procedure	Blood Count Complete Auto&Auto Difrntl Wbc Count,nebulization with ventoline solution,PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION,CEFTRIAXONE-TABUK IV,Administered	
	CPT code85025,94640,0188-135906-2441,0195-107704-0801,96365,9	

intravenously, 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 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.

b. Laboratory Test:

c. Radiology / Investigations:

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

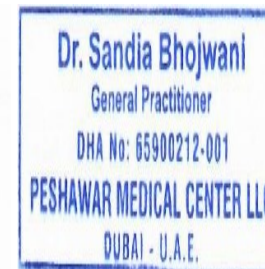
16.

PRESCRIPTION WITH DOSAGE & DURATION				
Code	Generic	Dosage	Duration	Instructions
No Prescriptions History Found				

Date: 15-01-25(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: 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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