



1.HealthNet Policy Number

I038-000-
115298215-012.
Authorization
Code:

2.Patient Name

PHILIPS CHINEDU ACHU

3.Patient Date of Birth & Sex

13-01-89(dd/mm/yy)

☒ Male ☐
Female

5.Nature of illness or Injury

Mobile No.0558757059

6.Are You the patient's primary physician

☐ Acute ☐ Chronic ☐ Emergency

7.Presenting Complaints:

☐ Yes ☐ No

pc ; runny nose , sneezing , dry cough, fever for 3 days

bp is elevated

no other med conditions

o/e hyperemia of pharynx

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Acute pharyngitis, unspecified, Allergic rhinitis, unspecified

ICD Code J02.9, J30.9

12.Etiology:

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

14.Plan / Details of Management

a.Procedure: 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 9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

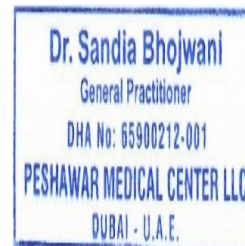
Code	Generic	Dosage	Duration	Instructions
0005-107001-0051	(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	CAPLETS (24S, BOX	5	Take 1 Tablets 1 Time(s) per Day For 5 Day(s) others

Code	Generic	Dosage	Duration	Instructions
0837-277601-1161	(OXOMEMAZINE : 0.33 MG/ML) SYRUP	SYRUP (150ML, PLASTIC BOTTLE)	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal
2733-646901-3851	(IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML (XYLOMETAZOLINE HCL : 0.5 MG/ML NASAL SPRAY	NASAL SPRAY (10ML, HDPE BOTTLE METERED DOSE SPRAY PUMP	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, FOIL STRIP	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening

Date: 17-01-25(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: 17-01-25(dd/mm/yy)

Signature of Insured / Claimint



Copy of NGI - Pharmacy

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

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