1.HealthNet Policy Number I038-000-120684878-01 2. Authorization Code:

2.Patient Name THAWDAR CHAN MYAE

3.Patient Date of Birth & Sex 08-04-99(dd/mm/yy) ☐ Male ☑ Female

Mobile No.0557745586

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

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

7.Presenting Complaints:

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAllergic rhinitis, unspecified, Sneezing, Nasal polyp, unspecified ICD Code J30.9, R06.7, J33.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedurePULMICORT,nebulization with ventoline solution, (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,Blood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein,Intramuscular injection CPT code0188-135906-2441,94640,0125-122107-1022,85025,86140,96372

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
6705-602506-3851	(HYDROXYPROPYLMETHYLCELLULOSE : 90 MG/ 30ML) NASAL SPRAY	NASAL SPRAY (30ML, SPRAY BOTTLE)	5	Take 1Spray 1 Time(s) per Day For 5 Day(s) others
0005-119803-1171	(PREDNISOLONE : 20 MG TABLETS	TABLETS (20S, BLISTER PACK	5	Take 1Tablets 1 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	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) evening
5251-624304-3591	(AZELASTINE HCL : 1 MG/G) (FLUTICASONE PROPIONATE : 0.365 MG/G) SUSPENSION FOR NASAL SPRAY	SUSPENSION FOR NASAL SPRAY (23G, AMBER GLASS BOTTLE+SPRAY PUMP+NASAL APPLICATOR)	15	Take 1Spray 2 Time(s) per Day For 15 Day(s) others

Date: 25-02-25(dd/mm/yy)

Doctor's Name DR Amaizah

Signature and Stamp

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Physician Code DHA-P-98486553 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: 25-02-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet