1.HealthNet Policy Number I038-000-116276447-01 2. Authorization Code:

2.Patient Name MAHMOUD YASSER ALSHIKH MAHMOUD

3.Patient Date of Birth & Sex 22-09-93(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0505441750

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

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

7.Presenting Complaints:

pc : sorethroat . fever , bodypain , headache ,nasal congesion loss of appetite

recurrent episodes ,

advised to see ENT specialist aferwards

o/e :

look irritable , dehydrated

swollen tonsils

hyperemic pharynx

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute recurrent tonsillitis, unspecified, Fever, unspecified, Cough, Wheezing, Dehydration ICD Code J03.91, R50.9, R05, R06.2, E86.0

12.Etiology:

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

14.Plan / Details of Management

a.Procedure9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000),CEFTRIAXONE-TABUK IV,(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION,nebulization with ventoline solution,PULMICORT,LACTATED RINGERS INJECTION USP,Administered intravenously,Culture Bacterial Blood Aerobic W/Id Isolates,CHLOROHISTOL 10MG,Intramuscular injection CPT code9.01,0195-107704-0801,0125-122107-1022,0442-106618-1001,94640,0188-135906-2441,0102-152902-1001,96365,87040,0005-111805-1021,96372

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
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	SUSPENSION FOR NEBULIZATION (2ML X 20, UNIT)	3	Take 1Solution 1 Time(s) per Day For 3 Day(s) others

Date: 26-03-25(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: 26-03-25(dd/mm/yy) Signature of Insued / Claimint

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