1.HealthNet Policy Number I038-000-117185927-01 2. Authorization Code:

2.Patient Name AHMED MOHAMED AMER ELMAGHRABY

3.Patient Date of Birth & Sex 01-09-95(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0563582854

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

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

7.Presenting Complaints:

patient came with the complain of high grade fever with body pain, cough and sore throat since morning

oe throat is hypermic

mild wheezing

came yesterday.

now on investigation:

CRP is high.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAcute pharyngitis, unspecified, Fever, unspecified, Cough, Pain, unspecified, Wheezing ICD Code J02.9, R50.9, R05, R52, R06.2

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureCEFTRIAXONE-TABUK IV,LACTATED RINGER'S INJECTION USP,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,Administered intravenously,PULMICORT,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000),Intramuscular injection

CPT code0195-107704-0801,0439-152905-1001,0125-122107-1022,96365,0188-135906-2441,9.01,96372

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

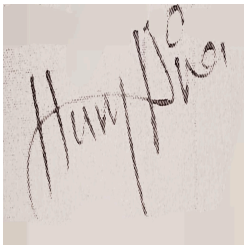
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
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) others

Date: 09-04-25(dd/mm/yy)

Doctor's Name Humaira

Signature and Stamp



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Physician Code DHA-P-54155530 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: 09-04-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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HealthNet