



1. HealthNet Policy Number

I038-000-
121782138-01

2.
Authorization
Code:

2. Patient Name

SHWE WAH WIN

3. Patient Date of Birth & Sex

10-10-96(dd/mm/yy)

☐ Male ☒ Female

Mobile No. 0565623588

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

painful little blisters over left side of upper lips since 4 days

pain and itching while smiling

itching and redness in eyes also

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis Herpesviral vesicular dermatitis, Acute atopic conjunctivitis, bilateral

ICD Code B00.1, H10.13

12. Etiology:

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

14. Plan / Details of Management

a. Procedure CHLOROHISTOL 10MG, Intramuscular injection, 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 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 0005-111805-1021, 96372, 9

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

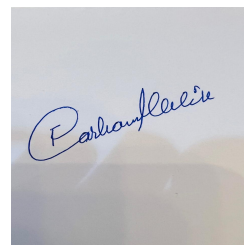
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0880-102415-0151	(ACYCLOVIR : 5% W/V) CREAM	CREAM (15G, COLLAPSIBLE TUBE)	10	Take 1 Cream 2 Time(s) per Day For 10 Day(s) others
0333-102402-1171	(ACYCLOVIR : 400 MG) TABLETS	TABLETS (50S, BLISTER PACK)	10	Take 1 Tablets 1 Time(s) per Day For 10 Day(s) others
0031-119704-0371	(CHLORAMPHENICOL : 0.5%) EYE DROPS	EYE DROPS (10ML, DROPPER BOTTLE)	5	Take 2 Drops 1 Time(s) per Day For 5 Day(s) others
0320-148701-1171	(LORATADINE : 10 MG) TABLETS	TABLETS (10S, BLISTER PACK)	7	Take 1 Tablets 1 Time(s) per Day For 7 Day(s) evening

Date: 22-04-25(dd/mm/yy)

Doctor's Name Dr.Farhan Iyas

Signature and Stamp



Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Physician Code DHA-P-6441782 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: 22-04-25(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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