



1. HealthNet Policy Number

I038-000-
121057163-01

2.
Authorization
Code:

2. Patient Name

KHIN PA PA AUNG

3. Patient Date of Birth & Sex

18-01-88(dd/mm/yy)

☐ Male ☒ Female

Mobile No. 0523556229

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

pt came with low back pain . for two days

pt also have white colour vaginal discharge along with itching for one week

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis Low back pain, Pain, unspecified, Candidiasis of vulva and vagina

ICD Code M54.5, R52, B37.3

12. Etiology:

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

14. Plan / Details of Management

a. Procedure CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION, PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION, Intramuscular injection, Administered intravenously, 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 0005-149902-1021, 2190-106618-1001, 96372, 96365, 9

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

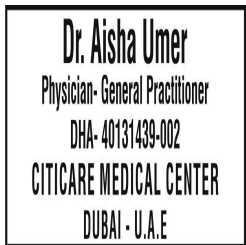
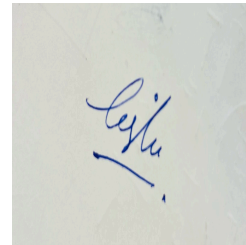
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0096-140503-1241	(CLOTRIMAZOLE : 500 MG) VAGINAL TABLETS	VAGINAL TABLETS (1S, STRIP + APPLICATOR)	5	Take 1 Tablets 1 Time(s) per Day For 5 Day(s) others
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (100G, TUBE)	7	Take 1 Gel 2 Time(s) per Day For 7 Day(s) others
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (9S, SACHET)	5	Take 1 Powder 2 Time(s) per Day For 5 Day(s) others
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	SUGAR COATED TABLETS (30S, BLISTER PACK)	5	Take 1 Tablets 2 Time(s) per Day For 5 Day(s) others

Date: 23-04-25(dd/mm/yy)

Doctor's Name AISHA

Signature and Stamp



Physician Code DHA-P-40131439 HNM Code

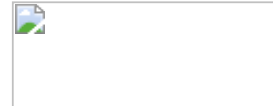
Authorization

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: 23-04-25(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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