



1. HealthNet Policy Number

I038-000-
117931762-012.
Authorization
Code:

2. Patient Name

MD NAZIM UDDIN ALI AHMED

3. Patient Date of Birth & Sex

24-01-87(dd/mm/yy)

☒ Male ☐
Female

Mobile No. 0501655603

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

follow up

sore throat

dry cough

headache

o/e hyperemia and chest is normal

crp high

iv antibiotic given

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acute pharyngitis, unspecified, Cough, Headache, unspecified

ICD Code J02.9, R05, R51.9

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: CEFTRIAXONE-TABUK IV, (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, Administered intravenously, 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 families 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 0195-107704-0801, 0125-
122107-1021, 96365, 96372, 9

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

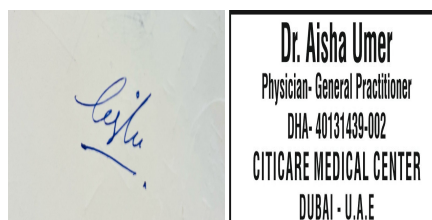
Code	Generic	Dosage	Duration	Instructions
0097-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (3S, BLISTER)	5	Take 1 Tablets 2 Time(s) per Day For 5 Day(s) others

Date: 06-05-25(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: 06-05-25(dd/mm/yy)

Signature of Insured / Claimant

Copy of NGI - Pharmacy

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

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