



1. HealthNet Policy Number

I038-000-
115298230-01

2.
Authorization
Code:

2. Patient Name

Waqar Ahmad Manzoor Ahmad

3. Patient Date of Birth & Sex

05-08-93(dd/mm/yy)

☒ Male ☐
Female

Mobile No. 0588210257

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

frontal headache

there is swelling on the left back side

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Episodic tension-type headache, intractable, Pain, unspecified

ICD Code G44.211, R52

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: Blood Count Complete Auto & Auto Diff, Wbc Count, C-Reactive Protein, 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 patient's 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 85025, 86140, 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
4884-622202-1171	(SERRAPEPTASE : 10 MG) TABLETS	TABLETS (30S, BLISTER)	5	Take 1 Tablet 2 Time(s) per Day For 5 Day(s) others
0005-107902-1171	(IBUPROFEN : 400 MG) TABLETS	TABLETS (24S, BLISTER PACK)	5	Take 1 Tablet 2 Time(s) per Day For 5 Day(s) others

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

Doctor's Name Dr. Farhan Ilyas

Signature and Stamp

Dr. Farhan 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: 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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