



1.HealthNet Policy Number

I038-000-

118180006-01

2. Authorization

Code:

2.Patient Name

ABDULRAHMAN MUSA BALA

3.Patient Date of Birth & Sex

20-07-89(dd/mm/yy)

☒ Male ☐ Female

Mobile No.0582130863

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

cough dry

runny nose

nasal congestion

headache

body ache

o/e

hyperemia

chest congestion

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Acute upper respiratory infection, unspecified, Cough, Wheezing

ICD Code J06.9, R05, R06.2

12.Etiology:

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

14.Plan / Details of Management

a.Procedure: 9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000), nebulization with ventoline solution, PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION, (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, Intramuscular injection, CEFTRIAXONE-TABUK IV, Administered intravenously

CPT code: 9.01, 94640, 0188-135906-2441, 0125-122107-1022, 96372, 0195-107704-0801, 96365

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

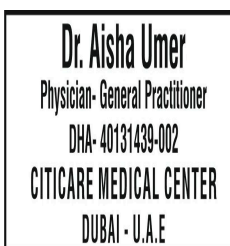
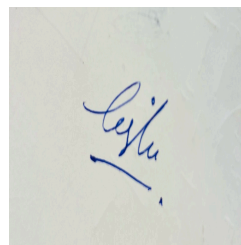
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0005-938301-3381	(CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET	CAPLET-TABLET (30S, BLISTER)	5	Take 1 Tablets 2 Time(s) per Day For 5 Day(s) others
0139-116201-0391	(AMOXICILLIN : 250 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	Take 1 Tablets 2 Time(s) per Day For 5 Day(s) others

Date: 08-05-25(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: 08-05-25(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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