



1.HealthNet Policy Number

I038-000-
120576995-012.
Authorization
Code:

2.Patient Name

HASNAE YALA

3.Patient Date of Birth & Sex

07-11-98(dd/mm/yy)

☐ Male ☒ Female

Mobile No.0542185163

5.Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

rash all over body after strating lower back pain medications , tolperisone

o/e : erhtmatous plaques on neck , face , arms , belly , black

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagonosisi Rash and other nonspecific skin eruption, Allergy status to other drug/meds/biol
subst

ICD Code R21, Z88.8

12.Etiology:

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

14.Plan / Details of Management

a.Procedure(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,
(CHLORPHENIRAMINE : 10 MG) INJECTION,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 familys 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 code0125-122107-1022,0046-
111801-0511,96372,9

b.Laboratiry 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
No Prescriptions History Found				

Date: 24-05-25(dd/mm/yy)

Doctor's Name DR Amaizah

Signature and Stamp

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Physician Code DHA-P-98486553 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: 24-05-25(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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