



1.HealthNet Policy Number

I038-000-
118061502-012.
Authorization
Code:

2.Patient Name

DELIA TESORO REPILLO

3.Patient Date of Birth & Sex

13-01-76(dd/mm/yy)

☐ Male ☒ Female

Mobile No.0582451975

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 LEFT EYE ITCHNESS ALONG WITH MILD SWELLING ON UPPER EYE LID

OE EYE IS CLEAR NO REDNESS

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

Diagnosis: Acute atopic conjunctivitis, left eye, Edema of left upper eyelid

ICD Code H10.12, H02.844

12.Etiology:

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

14. Plan / Details of Management

a.Procedure: 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 9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

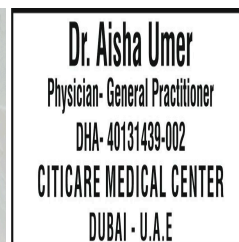
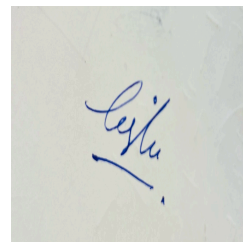
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
2717-707401-0381	(BIBROCATOL : 2%) EYE OINTMENT	EYE OINTMENT (5G, ALUMINIUM TUBE)	5	Take 1 Ointment 1 Time(s) per Day For 5 Day(s) others
1009-252806-0371	(PROPYLENE GLYCOL : 0.6%) EYE DROPS	EYE DROPS (10ML, DROPPER BOTTLE)	5	Take 1 Drops 2 Time(s) per Day For 5 Day(s) others

Date: 27-05-25(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: 27-05-25(dd/mm/yy)

Signature of Insured / Claimant

Copy of NGI - Pharmacy

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

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