1.HealthNet Policy Number I038-000-122692642-01 2. Authorization Code:

2.Patient Name NILIMA MANDAL DEVENDRA NATH MANDAL

3.Patient Date of Birth & Sex 16-07-89(dd/mm/yy) ☐ Male ☑ Female

Mobile No.+918240375676

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 the complain of irregular periods for the last six month

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

Diagonosisi Irregular menstruation, unspecified, Dysmenorrhea, unspecified, Polycystic ovarian syndrome ICD Code N92.6, N94.6, E28.2

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 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.,Blood Count Complete Auto&Auto Difrntl Wbc Count,Thyroid Stimulating Hormone Tsh,Triiodothyronine T3 Total Tt3,Estradiol,Gonadotropin Luteinizing Hormone,Gonadotropin Follicle Stimulating Hormone CPT code9,85025,84443,84480,82670,83002,83001

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

16.

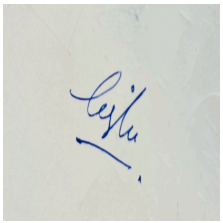
PRESCRIPTION WITH DOSAGE & DURATION

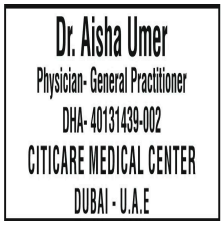
| Code | Generic | Dosage | Duration | Instructions |
|---|---|---|---|---|
| No Prescriptions History Found | | | | |

Date: 30-05-25(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: 30-05-25(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)
NGI House Building, P.O. Box 154, Deira, Dubai, Tel: +971 4 211 5800, Fax: +971 4 250 2854, Email: ngico@emirates.net.ae, Website: www.ngi.ae