



1. HealthNet Policy Number

I038-000-115298141-01

2. Authorization Code:

2. Patient Name

Rosaly Ignacio Arellano

3. Patient Date of Birth & Sex

12-06-76(dd/mm/yy)

☐ Male ☒ Female

Mobile No. 0501785987

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

Severe cough and body pain and sore throat since yesterday 22/10/2023 and severe cough since today and wheezing
no history of asthma

history of using warfarin for coagulopathy since 10 years

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acute pharyngitis, unspecified, Acute bronchitis, unspecified,
Chills (without fever), Fever, unspecified

ICD Code J02.9, J20.9, R68.83, R50.9

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: nebulization with ventoline solution, VENTOLIN
NEBULES, PULMICORT, Gp Consultation

CPT code 94640, 0006-124513-2071, 0188-135906-2441, 9

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

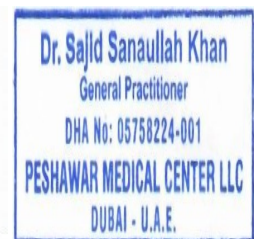
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0005-116801-1162	(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	SYRUP (5ML X 20, SACHET)	7	Take 5ML 3 Time(s) per Day For 7 Day(s) others
0788-106705-1171	(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	TABLETS (24S, BLISTER PACK)	6	Take 1 Tablets 4 Time(s) per Day For 6 Day(s) others
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	10	Take 1 Tablets 2 Time(s) per Day For 10 Day(s) others

Date: 23-10-23(dd/mm/yy)

Doctor's Name Sajid Sanaullah

Signature and Stamp



Physician Code DHA-P-5758224 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: 23-10-23(dd/mm/yy)

Signature of Insured / Claimant

Copy of NGI - Pharmacy

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

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