



1. HealthNet Policy Number

I038-000-
115298209-012. Authorization
Code:

2. Patient Name

Sobish Pullarathara Balan

3. Patient Date of Birth & Sex

16-05-86(dd/mm/yy)

☒ Male ☐ Female

Mobile No. 0509803581

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints: from 3 days ago 27/11/2023 has fever and cough and body pain

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Acute pharyngitis, unspecified, Acute bronchitis, unspecified

ICD Code J02.9, J20.9

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner., (SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION, nebulization with ventoline solution, (DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION, (CEFTRIAXONE : 1 G) POWDER FOR INJECTION, Intramuscular injection

CPT code 9.1, 0006-124513-2071, 94640, 0125-122107-1021, 0195-107704-0801, 96372

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
0252-107001-1171	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	10	Take 1 Tablets 2 Time(s) per Day For 10 Day(s) others
0045-168101-1171	(DIPHENHYDRAMINE : 30 MG) (CAFFEINE : 7.5 MG) (EPHEDRINE : 7.5 MG) (PARACETAMOL : 300 MG) TABLETS	TABLETS (20S, BOX)	10	Take 1 Tablets 2 Time(s) per Day For 10 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	TABLETS (14S, BLISTER PACK)	7	Take 1 Tablets 2 Time(s) per Day For 7 Day(s) others

Date: 30-11-23(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: 30-11-23(dd/mm/yy)

Signature of Insured / Claimant

Copy of NGI - Pharmacy

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

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