1.HealthNet Policy Number I038-000-117427085-01 2. Authorization Code:

2.Patient Name AUNG ZAW HTAY

3.Patient Date of Birth & Sex 18-10-91(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0543909211

5.Nature of illness or Injury ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician ☐ Yes ☐ No

7.Presenting Complaints:High fever and body pain started 4/12/2023 not better since started the medications

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisBronchopneumonia, unspecified organism, Acute bronchitis, unspecified ICD Code J18.0, J20.9

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureSODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION,DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION,CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION,CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION,IV fluid admisitration,Intravenous Injection,nebulization with ventoline solution,PULMICORT,VENTOLIN NEBULES,Blood Count Complete Auto&Auto Difrntl Wbc Count,C-Reactive Protein,Sedimentation Rate Rbc Non-Automated,9.019.01 - (9.01) - Follow Up - Consultation GP - (AED 0.0000)

CPT code0102-100104-1001,0125-122107-1022,0005-149902-1021,0195-107704-0801,96360,96374,94640,0188-135906-2441,0006-124513-2071,85025,86140,85651,

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

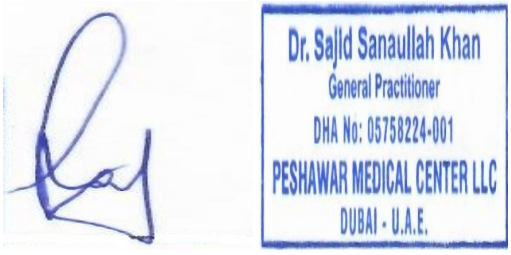
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
No Prescriptions History Found				

Date: 07-12-23(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: 07-12-23(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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HealthNet