



1.HealthNet Policy Number

I038-000-
119574145-012.
Authorization
Code:

2.Patient Name

Gideon Omamode Egberoh

3.Patient Date of Birth & Sex

19-09-82(dd/mm/yy)

☒ Male ☐
Female

Mobile No.0528981216

5.Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician

☐ Yes ☐ No

7.Presenting Complaints:

C/O ITCHING BETWEEN DIGITS OF BOTH FEET ON &OFF

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevant Past Medical/Surgical History

DiagnosisOther pruritus

ICD Code L29.8

12.Etiology:

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

14.Plan / Details of Management

a.ProcedureOffice 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 families 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 code9

b.Laboratory Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

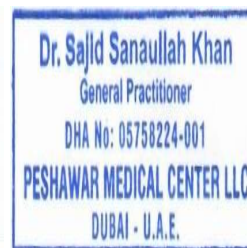
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0027-109206-0151	(TERBINAFINE (AS HCL) : 1%) CREAM	CREAM (15G, TUBE)	30	Take 1Cream 3 Time(s) per Day For 30 Day(s) others
0031-109204-1171	(TERBINAFINE (AS HCL) : 250 MG) TABLETS	TABLETS (7S, BLISTER PACK)	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others

Date: 04-03-24(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: 04-03-24(dd/mm/yy)

Signature of Insured / Claimint

Copy of NGI - Pharmacy

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

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