1.HealthNet Policy Number: I038-000-119883596-01 2. Authorization Code:

2.Patient Name: KYAW SWAR HEIN

3.Patient Date of Birth & Sex: 27-04-00(dd/mm/yy) ☑ Male ☐ Female

Mobile No.0566309656

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

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

7.Presenting Complaints:

Recurrent pruritic rash since the past two days,

Rashes is not present at the time of this consultation.

It is however said to be worst at night.

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiAllergic contact dermatitis, unspecified cause ICD Code L23.9

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 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. CPT code9

b.Laboratiry Test:

c.Radiology / Investigations:

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

16.

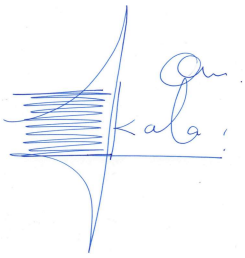
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	TABLETS (20S, BLISTER PACK)	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening
1111-183202-0391	(FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS	FILM COATED TABLETS (30S, BLISTER PACK)	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others

Date: 16-03-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp



Physician Code DHA-P-28040827 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: 16-03-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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

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HealthNet