



1.HealthNet Policy Number	2. I038-000-115438148-01 Authorization Code:
2.Patient Name	DANIEL OJONUGWA ADUKU
3.Patient Date of Birth & Sex	15-05-83(dd/mm/yy) ☒ Male ☐ Female
5.Nature of illness or Injury	Mobile No.526770890 ☐ Acute ☐ Chronic ☐ Emergency
6.Are You the patient's primary physician	☐ Yes ☐ No
7.Presenting Complaints:c/o pain in right side of chest and radiatin g to back ,mainly it increase with movement and while lifting something	
8.Duration of Symptoms:	
9.Onset of Condition:	
10.Relevent Past Medical/Surfgical History	
DiagonosisiMyalgia of auxiliary muscles, head and neck, Cramp and spasm	ICD Code M79.12, R25.2
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.	
b.Laboratiry Test:	
c.Radiology / Investigations:	
CPT code9	

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
2093-596002-0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	GEL (50G, TUBE)	7	Take 1Gel 2 Time(s) per Day For 7 Day(s) after meal
0717-226501-2401	(EPERISONE : 50 MG) SUGAR COATED TABLETS	SUGAR COATED TABLETS (30S, BLISTER PACK)	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	POWDER FOR SOLUTION (30S, SACHET)	7	Take 1sachet 2 Time(s) per Day For 7 Day(s) after meal

Date: 17-03-24(dd/mm/yy)

Doctor's Name Maimoona

Signature and Stamp

Physician Code DHA-P-65822348 HNM Code

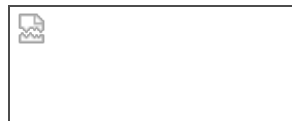
Authorization

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: 17-03-24(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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