



1. HealthNet Policy Number

1038-000-
118996243-012.
Authorization
Code:

2. Patient Name

ZAHID ULLAH BAKHMIR ZADA

3. Patient Date of Birth & Sex

01-03-89(dd/mm/yy)

☒ Male ☐
Female

Mobile No. 971505191251

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints:

Recurrent low back pain.

Pain radiate from both flanks to the groin

Calculus is suspected

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis: Calculus of kidney with calculus of ureter, Low back pain

ICD Code N20.2, M54.5

12. Etiology:

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

14. Plan / Details of Management

a. Procedure: Urns Dip Stick/Tablet Reagent Auto Microscopy, Intramuscular injection, CLOFEN, Office 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 family's 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 code 81001, 96372, 0005-149902-1021, 9

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

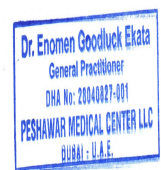
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0027-149903-0391	(DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS	FILM COATED TABLETS (10S, BLISTER PACK)	5	Take 1 Tablets 2 Time(s) per Day For 5 Day(s) after meal

Date: 29-03-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp



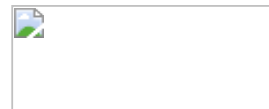
Physician Code DHA-P-28040827 HNM Code

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: 29-03-24(dd/mm/yy)

Signature of Insured / Claimant

Copy of NGI - Pharmacy

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

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