



1. HealthNet Policy Number

I038-000-
118061502-012. Authorization
Code:

2. Patient Name

DELIA TESORO REPILLO

3. Patient Date of Birth & Sex

13-01-76(dd/mm/yy)

☐ Male ☒ Female

Mobile No. 0582451975

5. Nature of illness or Injury

☐ Acute ☐ Chronic ☐ Emergency

6. Are You the patient's primary physician

☐ Yes ☐ No

7. Presenting Complaints: Patient had seafood 1.30pm, then she started itching and rashes in all over the body. She doesn't have any breathing issues now, Advice to patient "avoid the sea food"

8. Duration of Symptoms:

9. Onset of Condition:

10. Relevant Past Medical/Surgical History

Diagnosis Allergy to seafood

ICD Code Z91.013

12. Etiology:

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

14. Plan / Details of Management

a. Procedure CHLOROHISTOL 10MG, 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 patient's 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, Intramuscular injection

CPT code 0005-111805-1021, 9, 96372

b. Laboratory Test:

c. Radiology / Investigations:

15. In Case of Hospitalization: Date of Admission:

Date of Discharge:

16.

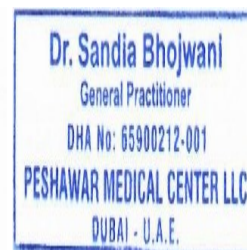
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
No Prescriptions History Found				

Date: 17-04-24(dd/mm/yy)

Doctor's Name SANDIA

Signature and Stamp



Physician Code DHA-P-65900212 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: 17-04-24(dd/mm/yy)

Signature of Insured / Claimant



Copy of NGI - Pharmacy

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

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