DENTAL TREATMENT FORM

Ref No.

Dear Doctor you are kindly requested to complete this Consultation Form and fax it to NAS Claims Center at 02-6766227.
For prescriptions, kindly use Prescription/ Advice Form.

PATIENT INFORMATION

NAME:	PRASHANT SHANKAR HEGDE SHANKAR MAHABAL HEGDE	**GIVEN NAME:**	PRASHANT SHANKAR HEGDE SHANKAR MAHABAL HEGDE
DATE OF BIRTH :	29-Oct-1972	**GENDER:**	Male
CARD NBR:	CC1C-RICC-DCDR-GDEA	**PAYER**	NAS - EN CN GN

CASE INFORMATION

DIAGNOSIS

K04.7 - Periapical abscess without sinus

AETIOLOGY

(Please indicate the exact cause in case of injuries)

PROCEDURE / MANAGEMENT PLANNED

(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS ORAL, (METRONIDAZOLE : 400 MG) TABLETS METRONIDAZOLE [400 MG], (*PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS *PANTOPRAZOLE (AS SODIUM) [20 MG], D0220 - intraoral - periapical first radiographic image, D0150 - comprehensive oral evaluation - new or established patient, D0484 - consultation on slides prepared elsewhere, D0150 - comprehensive oral evaluation - new or established patient

TREATING DENTAL SPECIALIST Abdulrahman

HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC

CONSULTATION DETAILS **NEW** ☐ **FOLLOW-UP** ☐ **CONSUTATION FEES**

Dr. Abdulrahman Al Tekreeti
General Dentist
DHA No: 84724128-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

DATE: 14-Jul-2024

DOCTOR'S SIGNATURE AND STAMP

I hear allow NAS authorized personnel to obtain any requisite medical details from my current and previous physicians and case diles.

BENEFICIARYS' SIGNATURE

NAS Administration Services, P.O.Box: 44505, Abu Dhabi, UAE. Te:02-6777997, FaxL02-6766227