

**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.

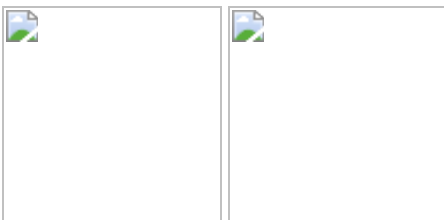
**PATIENT INFORMATION**

|                        |                     |                    |                   |
|------------------------|---------------------|--------------------|-------------------|
| <b>NAME:</b>           | DOAA ABDEL RAHMAN   | <b>GIVEN NAME:</b> | DOAA ABDEL RAHMAN |
| <b>DATE OF BIRTH :</b> | 18-Apr-1991         | <b>GENDER:</b>     | Female            |
| <b>CARD NBR:</b>       | 4A1A-ARCC-DCDG-4DEA | <b>PAYER</b>       | NAS - RN,RN+      |

**CASE INFORMATION**

|                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>DIAGNOSIS</b>                                                                                                                                                                                                                                                                                                              |
| K04.02 - Irreversible pulpitis, K05.323 - Chronic periodontitis, generalized, severe, K02.52 - Dental caries on pit and fissure surfc penetrat into dentin                                                                                                                                                                    |
| <b>AETIOLOGY</b>                                                                                                                                                                                                                                                                                                              |
| (Please indicate the exact cause in case of injuries)                                                                                                                                                                                                                                                                         |
| <b>PROCEDURE / MANAGEMENT PLANNED</b>                                                                                                                                                                                                                                                                                         |
| (AMOXICILLIN : 500 MG) CAPSULES ORAL, (IBUPROFEN : 600 MG) FILM COATED TABLETS ORAL, (AMOXICILLIN : 500 MG) CAPSULES ORAL, 10 - Consultation Specialist, D3310 - endodontic therapy, anterior tooth (excluding final restoration), D2740 - crown - porcelain/ceramic, D2392 - resin-based composite - two surfaces, posterior |

|                                                      |                                     |                                           |                         |
|------------------------------------------------------|-------------------------------------|-------------------------------------------|-------------------------|
| <b>TREATING DENTAL SPECIALIST Dr Raseena</b>         |                                     |                                           |                         |
| <b>HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC</b> |                                     |                                           |                         |
| <b>CONSULTATION DETAILS</b>                          | <b>NEW</b> <input type="checkbox"/> | <b>FOLLOW-UP</b> <input type="checkbox"/> | <b>CONSUTATION FEES</b> |

**DATE: 20-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