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

CASE INFORMATION

DIAGNOSIS

K04.02 - Irreversible pulpitis, K05.323 - Chronic periodontitis, generalized, severe, K02.52 - Dental caries on pit and fissure surfc penetrat into dentin

AETIOLOGY

(Please indicate the exact cause in case of injuries)

PROCEDURE / MANAGEMENT PLANNED

D0150 - comprehensive oral evaluation - new or established patient

TREATING DENTAL SPECIALIST Dr Raseena

HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC

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

DATE: 21-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