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:	PRASANNA ALPARA BALAKRISHNAN	**GIVEN NAME:**	PRASANNA ALPARA BALAKRISHNAN
DATE OF BIRTH :	04-Jun-1988	**GENDER:**	Female
CARD NBR:	F2KI-FGE2-C2C8-ICDE	**PAYER**	NAS - SRN WN

CASE INFORMATION

DIAGNOSIS

K01.1 - Impacted teeth

AETIOLOGY

(Please indicate the exact cause in case of injuries)

PROCEDURE / MANAGEMENT PLANNED

(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS CLAVULANIC ACID/AMOXICILLIN [125 MG|500 MG], (IBUPROFEN : 600 MG FILM COATED TABLETS ORAL, D0001 - Consultation Dentist, D0150 - comprehensive oral evaluation - new or established patient

TREATING DENTAL SPECIALIST Raseena

HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC

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

DATE: 05-Dec-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