

**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.

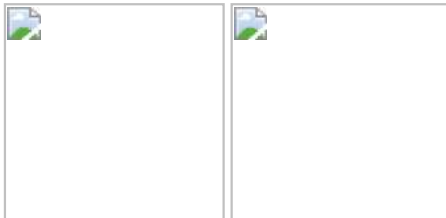
PATIENT INFORMATION

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