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:	ATHUL MAVOLI JAYARAJAN MAVOLI	**GIVEN NAME:**	ATHUL MAVOLI JAYARAJAN MAVOLI
DATE OF BIRTH :	16-Aug-1992	**GENDER:**	Male
CARD NBR:	RNP3-1NLM-VMVP-3VAE	**PAYER**	NAS - EN CN GN

CASE INFORMATION

DIAGNOSIS

K05.329 - Chronic periodontitis, generalized, unspecified severity

AETIOLOGY

(Please indicate the exact cause in case of injuries)

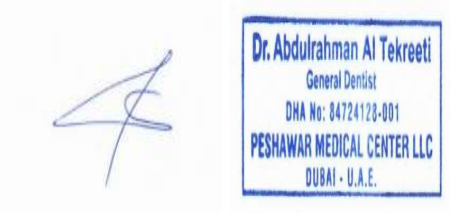
PROCEDURE / MANAGEMENT PLANNED

D1110 - prophylaxis - adult

TREATING DENTAL SPECIALIST Abdulrahman

HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC

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



DATE: 21-Jan-2025

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