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:	Saleh Abdulla Saleh Ahmad	**GIVEN NAME:**	Saleh Abdulla Saleh Ahmad
DATE OF BIRTH :	18-Dec-1977	**GENDER:**	Male
CARD NBR:	6508-587B-4C47-E99F	**PAYER**	NAS - EN CN GN

CASE INFORMATION

DIAGNOSIS

K05.10 - Chronic gingivitis, plaque induced

AETIOLOGY

(Please indicate the exact cause in case of injuries)

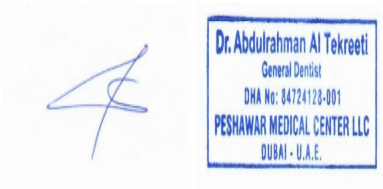
PROCEDURE / MANAGEMENT PLANNED

D0150 - comprehensive oral evaluation - new or established patient

TREATING DENTAL SPECIALIST Abdulrahman

HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC

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



DATE: 26-Jul-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

7/26/2025 3:36:49 PM