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:	NAJEEB ULLAH ABDUL RAZIQ	**GIVEN NAME:**	NAJEEB ULLAH ABDUL RAZIQ
DATE OF BIRTH :	01-Apr-1991	**GENDER:**	Male
CARD NBR:	1922-AE4C-DCDG-RDEA	**PAYER**	NAS - SRN WN

CASE INFORMATION

DIAGNOSIS

K04.7 - Periapical abscess without sinus

AETIOLOGY

(Please indicate the exact cause in case of injuries)

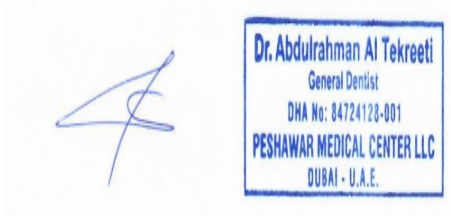
PROCEDURE / MANAGEMENT PLANNED

D0150 - comprehensive oral evaluation - new or established patient, D0220 - intraoral - periapical first radiographic image

TREATING DENTAL SPECIALIST Abdulrahman

HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC

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



DATE: 09-Aug-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