

**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.

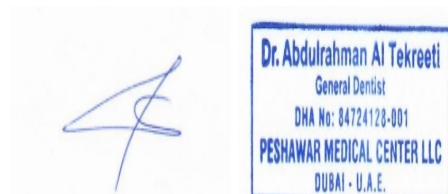
PATIENT INFORMATION

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
D3320 - endodontic therapy, premolar tooth (excluding final restoration), D2392 - resin-based composite - two surfaces, posterior

TREATING DENTAL SPECIALIST Abdulrahman			
HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC			
CONSULTATION DETAILS	NEW ☐	FOLLOW-UP ☐	CONSUTATION FEES

**DATE: 23-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



Empty rectangular box for the beneficiary's signature.

8/23/2025 6:30:33 PM

NAS Administration Services, P.O.Box: 44505, Abu Dhabi, UAE. Te:02-6777997, FaxL02-6766227