

**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:	VIGNESH SHANMUGAM SHANMUGAM	GIVEN NAME:	VIGNESH SHANMUGAM SHANMUGAM
DATE OF BIRTH :	29-Sep-1991	GENDER:	Male
CARD NBR:	C341-C33A-7A42-2ADA	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 INDHUJA
HOSPITAL / CLINIC Irham Medical Center Arjan

CONSULTATION DETAILS**NEW**☐**FOLLOW-UP**☐**CONSUTATION FEES****DATE: 11-Jan-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