

**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.

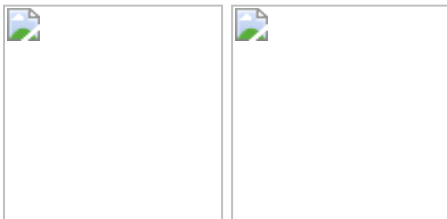
PATIENT INFORMATION

NAME:	PRASANTH PALANIAPPAN	GIVEN NAME:	PRASANTH PALANIAPPAN
DATE OF BIRTH :	22-Aug-1990	GENDER:	Male
CARD NBR:	C441-C33A-7ADD-4ADA	PAYER	NAS - EN CN GN

CASE INFORMATION

DIAGNOSIS
K02.62 - Dental caries on smooth surface penetrating into dentin
AETIOLOGY
(Please indicate the exact cause in case of injuries)
PROCEDURE / MANAGEMENT PLANNED
D0220 - intraoral - periapical first radiographic image, 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: 16-Feb-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