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