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