DENTAL TREATMENT FORM

Dear Doctor, you are kindly requested to complete this Consultation Form and fax it to NAS Claims Centre at 02- 6766227. **For prescriptions, kindly use Prescription/Advice Form**.

PATIENT INFORMATION

FAMILY NAME _____ **GIVEN NAME** _____

DATE OF BIRTH _____ **GENDER** _____

CARD NBR: _____ **PAYER** _____

CASE INFORMATION

DIAGNOSIS

_____

AETIOLOGY

_____

(Please indicate the exact cause in case of injuries)

PROCEDURE/ MANAGEMENT PLANNED

TREATING DENTAL SPECIALIST _____

HOSPITAL /CLINIC _____

CONSULTATION DETAILS **NEW** ☐ **FOLLOW-UP** ☐ **CONSULTATION FEES** _____

DOCTOR'S SIGNATURE AND STAMP _____ **DATE** _____

I hereby allow NAS authorized personnel to obtain any requisite medical details from my current and previous physicians and/or case files.

BENEFICIARYS' SIGNATURE _____