PRESCRIPTION /ADVICE FORM

Ref No_____(IMPORTANT: Please copy from the Consultation Form)

PATIENT NAME _____

DIAGNOSIS _____

NATURE OF TREATMENT : (Please use separate sheet for each group)

☐ **Pharmacy** ☐ **Diagnostic** ☐ **Physiotherapy** ☐ **Others**

ITEM	QUANTITY
Doctor's Signature and Stamp	

FOR PROVIDERS USE

CARD NO _____ **AMOUNT CLAIMED** _____

PAYER _____ **DATE** _____

NAME _____ **Signature and Stamp:**

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

BENEFICIARYS' SIGNATURE _____

NAS Administration Services , P.O Box 44505 Abu Dhabi , UAE Tel : 02-6777997 Fax : 02- 6766227