MedNet Global Healthcare Solutions L.L.C.

Paid-up capital AED 5,000,000

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The preferred choice for healthcare solutions

MEMBER DETAILS				BENEFIT DETAILS
MEMBER NAME	: SANA ALI			Please follow benefits list for other deductible/copayment details
INSURANCE PLAN	: INS047 / ADAMJEE INSURANCE COMPANY LIMITED (DUBAI BRANCH)_162			
DHA MEMBER ID	: I047-036-116492461-01			
EID	: 784-1981-1963207-3	DOB	: 02 Feb 1981	
CARD NUMBER	: 097111620208618402	GENDER	: FEMALE	
MOBILE NUMBER	: 507869909	START DATE	: 14 Jan 2022	
MEMBER NETWORK	: Silk Road	END DATE	: 13 Jan 2023	

PRE-APPROVAL PROTOCOL:Please follow standard MedNet approval protocols.

SUBJECTIVE

OBJECTIVE

K05.10 - Chronic gingivitis (plaque induced

TEMP: PR: RR: BP: WEIGHT:

PHARMACEUTICALS

DIAGNOSTIC PROCEDURES

K05.10

D1110 - Prophylaxis 215.46
D0330 - Panoramic Xray 104.40

OPG & SCALE & POLISH

Dr. Rutul Desai
General Dentist
DENTISTREE DHA-44339326-001
DENTISTREE DENTAL CLINIC

Facility Name: DENTISTREE DENTAL CLINIC - JUMEIRAH
Telephone No:
Physician's Name:

Physician's Stamp and Signature:

Patient Registered by: Sherlyn Pun-an
Date and Time: 23/May/2022 04:54 pm
Card Holder's Signature:

"I hereby authorize any MedNet personnel to access my medical file"

DISCLAIMER:
ALL SERVICES OUTSIDE PRE-APPROVAL PROTOCOL ARE SUBJECT TO RESTROSPECTIVE MEDICAL EVALUATION UPON CLAIM SUBMISSION.
CLAIMS PROCESSING IS SUBJECT TO CONTRACTUAL TARIFF.

rize and / or his / her associates to render treatment and administering or any medications and / or anesthetics deemed y for my treatment.

been given the opportunity to ask any questions regarding the nature and purpose of crown and / or bridge treatment and have eived answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may b sociated with any phase of this treatment in hopes of obtaining the desired result, which may or may not be achieved. The fee (s) (if applicable), for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Dr. Priyanka Kiran and / or his associates to render treatment and administering or any medications and / or anesthetic deemed necessary for my treatment.

☐ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

☐ I refuse to give my consent for the proposed treatment(s) as described above and have been explained the potential consequences associated with this refusal.

Sign here, only if all of your questions have been answered to your satisfaction

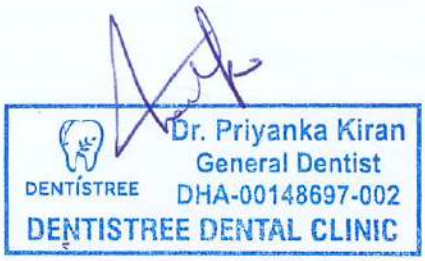
Walaa M F Luzon

02-Sep-2022

Patient's name | **Signature of Patient Legally authorized Representative** | **Date**

02-Sep-2022

Witness Signature | **Date**



02-Sep-2022

Dentist's Signature | **Date**