Medical Care Form

Claim number:wef23

h Insurance System Informa	Filling Instructions						
SAM code:			Write legibly				
	ID obligatoire						
Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:	Laura M 20	larhysa 1978-01-	Agreed healthcare network:				
Carte ID:	594565						
Full Name (first, middle, last):	Laura M 20	/larhysa 1978-01-					
Age:	45.8		Prescribing Doctor / orientation: 234f 34f 34f				
Marital Status :							
Gender :	Female						
edical Procedures:							
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : edical Procedures:	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, laura Natus): Age: Age: 45.8 Marital Status: Gender: Female Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Marital Status: Gender: Female edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Docto 234f 34f 34f Marital Status: Gender: Female Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctor / orien 234f 34f 34f Marital Status: Gender: Female Designation (Medical Coefficient Rate		

<u>lmportant:</u> The validity of this form cannot e	Total amount:		
date of issue	To be paid by the patient		
Assignment code		To be paid by the insurance company	

Information & Access To Health Care			2. Patient Policy			. Infos Referen enter	ce Medical		
Important: The validity of this form cannot exceed			exceed 5 d	d 5 days from the			Tota	al amount:	
date of issue						To be paid by the patient			he patient
Assignment code					To be paid by the insurance company			-	
				5.	. Det	ails Of Pa	aram	edical Procedu	ıres:
Date	Code	Code Designation (Medical acts)			Coefficient Rate		Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5 d			lays			Total amount:			
from t	the date o	of issue				To be	e paid	by the patient	
Assignment code				To be paid by the insurance company					
Pati	atient signature Signature and stamp medical Healthcare centre Doctor					d stamp of the			
Prescribed (Section Reserved For The				dicines	Section Reserved For The Pharmacist				
No: Dr	ugs			Dos	age(Quantity	Total	Cost	
perindopril tosilate teva 10 mg, comprimé pelliculé			né 32	3	32	1024			
	l			Tota	al am	nount:	1024	.00	
<u>Important:</u> The prescribing									

Prescrik each Doctor)	practitioner will ped (Section Reserved For indicate the duration of treatment for drug,	6. Medicines The Prescribing	Section Reserved For The Pharmacist	
and	this form is valid only for one pharmacy	To be paid by the patient (%)	1003.52	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	20.48	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		