## **Medical Care Form**

Claim number:34f34f

h Insurance System Informa	Filling Instructions				
	Write legibly				
	ID obligatoire				
Access To Health Care	2. Patient Policy		3. Infos Reference Medical Center		
Matricule:			Date and Time:		
Nom:	Dhiraj 2	000-06-18	Agreed healthcare network:		
Carte ID:	5677777	,			
Full Name (first, middle, last):	Dhiraj 2	000-06-18			
Age:	23.4		Prescribing Doctor / orientation: ecwe cwec wdec		
Marital Status :					
Gender :	Male				
edical Procedures:					
l ode	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, last): Age: 23.4  Marital Status: Gender: Male  Male  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Dhiraj 2000-06-18  Carte ID: 5677777  Full Name (first, middle, last): Age: 23.4  Marital Status: Gender: Male  edical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhiraj 2000-06-18  Agreed healthcare  Carte ID:  Full Name (first, middle, last):  Age:  23.4  Prescribing Doctor ecwe cwec wdec  Marital Status:  Gender:  Male  Designation (Medical  Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhiraj 2000-06-18  Agreed healthcare network  Carte ID:  Full Name (first, middle, last):  Age:  Age:  23.4  Prescribing Doctor / orient ecwe cwec wdec  Marital Status:  Gender:  Male  Designation (Medical Coefficient Pate)

<u>lmportant:</u> The validity of this form cannot	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 Referend enter	ce Medical			
<u>Imp</u>	ortant	<u>:</u> The v	alidity	y of this form cannot e	exceed	l 5 days	from the		Tota	il amount:
date of issue								To be paid by the patient		
Assignment code				To be paid by the insurance company						
5. Details Of Paramedical Procedures:						ıres:				
Date Code Designation (Medical acts)				Coefficient Rate		Rate	Total Cost			
Important: The validity of this form cannot exceed			l 5 days			Total amount:				
from the date of issue				To be	paid	by the patient				
Assignment code					To be paid by the insurance company					
Patient signature Signature and stamp medical Hea					ical Heal	Signature and stamp of the Doctor				
Prescribed (Section Reserved For			6. Med The Presci	dicines	Section Reserved					
No:	o: Drugs Dosage			Quantity	Total Cost					
	aripiprazole sandoz 10 mg, comprimé orodispersible			21	21	441				
				Total an	nount:	ınt: 441.00				
	<u>Ir</u>	<u>nporta</u>	<u>nt:</u> Ih	ie 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 (%)	88.20	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	352.80	
Sig	nature and stamp Prescribing Doctor	Signature and stamp Pharmacist		