## **Medical Care Form**

Claim number: 234

1. Health Insurance System Information		Filling Instructions				
SAM code:						
SAM: ID obligatoi						
Access To Health Care	2. Patient Policy		3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:	Prashar	nt 1997-10-28	Agreed healthcare network:			
Carte ID:	234					
Full Name (first, middle, last):	Prashar	nt 1997-10-28				
Age:	25.8		Prescribing Doctor / orientation: 34 34 34			
Marital Status :						
Gender :	Male					
4. Details Of Medical Procedures:						
l ode	Designation (Medical acts)		Coefficient	IRate	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: Prashar  Carte ID: 234  Full Name (first, middle, last):  Age: 25.8  Marital Status:  Gender: Male  edical Procedures:  Designation	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Prashant 1997-10-28  Carte ID: 234  Full Name (first, middle, last): Age: 25.8  Marital Status: Gender: Male  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 1997-10-28  Agreed healthcare  Carte ID:  234  Full Name (first, middle, last):  Age:  25.8  Prescribing Docto 34 34 34  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly    Dobligatoire	

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		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 Medica	I	
Important: The validity of this form cannot e		exceed 5 days from the		Total amount:				
date of issue						To be paid by the patient		
Assignment code					To be paid by the insurance company			
			5. Det	ails Of Paraı	me	dical Procedu	ıres:	
Date	Code	Designation (Medical	acts)	Coefficient		Rate	Total Cost	
Important: The validity of this form cannot ex from the date of issue		exceed 5 days	Total am		Total amount:			
					To be paid by the patient			
Assignment code To be p			To be paid l	by the insurance company				
Patient signature Signature and stamp medical Health			thcare centr	·e	Signature and Doctor	l stamp of	the	
			6. Med	licines				

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist	
No:	Drugs	Dosage	Quantity	Total Cost	
1	PERINDOPRIL TOSILATE TEVA 10 mg, comprimé pelliculé	10	1	1	

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist	
2	TRACRIUM 25 mg/2,5 ml (1 POUR CENT), solution injectable en ampoule	10	1	1	
eac	practitioner will indicate the duration of treatment for	Total amount:		2.00	
and	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		0.40	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		1.60	
	Signature and stamp Prescribing Doctor			cure and stamp Pharmacist	