Medical Care Form

Claim number:3e

1. Health Insurance System Information		Filling Instructions				
SAM code:						
		ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:	sourabl	า 2000-11-23	Agreed healthcare network:			
Carte ID:	123					
Full Name (first, middle, last):	sourabl	า 2000-11-23				
Age:	23.2		Prescribing Doctor / orientation: fwef wef wef			
Marital Status :						
Gender :	Male					
4. Details Of Medical Procedures:						
LOGE	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: sourabl Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Marital Status : Gender : Male Edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: sourabh 2000-11-23 Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Marital Status: Gender: Male edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Sourabh 2000-11-23 Full Name (first, middle, last): Age: Age: Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Sourabh 2000-11-23 Full Name (first, middle, last): Age: Age: Age: Date and Time: Prescribing Doctor / orient fwef wef wef Marital Status: Gender: Male Designation (Medical Coefficient Rate	

<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		s To Health Care	2. Patient Policy			Infos Referen enter	ce Medica	ı
Important: The validity of this form cannot		ry of this form cannot ε	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 Para	me	dical Procedu	ıres:	
Date	Code	Designation (Medical	acts)	Coefficient		Rate	Total Cost	
<u>lmportant:</u> The validity of this form cannot e from the date of issue		exceed 5 days			Total amount:			
				To be pa		by the patient		
Assignment code To be paid			To be paid	by	the insurance company			
Patient signature Signature and stamp medical Hea			medical Heal	thcare centr	e	Signature and Doctor	l stamp of	the
			6. Med	dicines				

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	1	200	2000	

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist	
2	aripiprazole sandoz 10 mg, comprimé orodispersible	1	30	1500	
	Important: The prescribing practitioner will indicate the duration of treatment for	Total amount:		3500.00	
and	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		0.00	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		2701.80	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist			