Medical Care Form

Claim number: 45345

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
		ID obligatoire					
Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:	sourabl	n 2000-11-23	Agreed healthcare network:				
Carte ID:	123						
Full Name (first, middle, last):	sourabl	h 2000-11-23					
Age:	23.2		Prescribing Doctor / orientation: 34t 34t 34t				
Marital Status :							
Gender :	Male						
4. Details Of Medical 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: sourabl Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Marital Status : Gender : Male edical Procedures: Code Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: sourabh 2000-11-23 Carte ID: 123 Full Name (first, middle, last): sourabh 2000-11-23 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 Agreed healthcare Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Prescribing Docto 34t 34t 34t Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Sourabh 2000-11-23 Full Name (first, middle, last): Age: Age: 23.2 Prescribing Doctor / orien 34t 34t 34t Marital Status: Gender: Male 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	l	
<u>Important:</u> 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 Pa	rame	edical Procedu	res:	
Date	Code	[Designation (Medical a	acts)	Coefficier	nt	Rate	Total Cost	
<u>lmportant:</u> The validity of this form cannot ex from the date of issue			xceed 5 days			Total amount:			
						by the patient			
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp medica			medical Heal	Signature and stamp of the Doctor			the		
Prescribed (Section Reserved For			6. Med	6. Medicines Section I			ction Rese	rved	

	scribed (Section Reserved For	6. Medicines The Prescribing		Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
1	tramadol eg l.p. 200 mg, comprimé à libération prolongée	10	100	10000

Prescribed (Section Reserved For Doctor)			dicines	Section Reserved For The Pharmacist	
2	aripiprazole sandoz 10 mg, comprimé orodispersible	30	30	90	
	Important: The prescribing practitioner will indicate the duration of treatment for	Total amount:		10090.00	
and	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		4000.00	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		6090.00	
Signature and stamp Prescribing Doctor			Signat	ture and stamp Pharmacist	