Medical Care Form

Claim number: 23r23

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
		ID obligatoire						
Access To Health Care			3. Infos Reference Medical Center					
Matricule: Primary			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: 23r 23r 23r					
Marital Status :								
Gender :	Male							
4. Details Of Medical Procedures:								
Lone	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: 23.2 Prescribing Docto 23r 23r 23r 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: 23.2 Prescribing Doctor / orient 23r 23r 23r 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			nfos Referen nter	ce Medica	ı		
Important: The validity of this form cannot exceed 5 day			exceed 5 days f	from the		Tota	l amount:		
date of issue				To be paid by the		ne patient			
Assignment code					To be paid by the insurance company				
5. Details				ails Of Para	med	dical Procedu	res:		
Date	Code		Designation (Medical a	acts)	Coefficient	F	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed from the date of issue			exceed 5 days		Т	otal amount:			
			To be pa			y the patient			
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp medical He			medical Heal	thcare centr	~ I	Signature and Doctor	stamp of	the	
,									

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

Prescribed (Section Reserved For Doctor)			dicines ribing	Section Reserved For The Pharmacist
2	perindopril tosilate teva 10 mg, comprimé pelliculé	20	20	400
	Important: The prescribing practitioner will indicate the duration of treatment for	Total amount:		500.00
each	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		500.00
Signature and stamp Prescribing Doctor			Signat	ture and stamp Pharmacist