Medical Care Form

Claim number: 3453

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:	Prashar	nt 1997-10-28	Agreed healthcare network:		
Carte ID:	234				
	Prashar	nt 1997-10-28			
Age:	25.8		Prescribing Doctor / orientation: 234 34 234		
Marital Status :					
Gender :	Male				
edical 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: Code Designa	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 234 34 234 Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Agreed healthcare networ Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Prescribing Doctor / orient 234 34 234 Marital Status: Gender: Male Pesignation (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			3. Infos Referer Center	nce Medical			
Important: The validity of this form cannot excee				exceed	5 days 1	from the		Tota	al amount:		
date of issue								To be paid by the patient			
Assignment code					To be paid by th insurance compan						
						5. Det	ails Of Pa	aram	nedical Procedi	ures:	
Date Code Designation (Medical acts)			Coefficient		Rate	Total Cost					
Important: The validity of this form cannot exceed			exceed	5 days			Total amount				
from the date of issue					To be	e paic	l by the patient				
Assignment code						To be paid by the insurance company					
Patient signature Signature and stamp medical Hea					cal Heal	Signature and stamp of the Doctor					
Prescribed (Section Reserved For Th				6. Med The Prescr	dicines	Section Reserved					
No:	Drugs					Oosage	Quantity	Tota	otal Cost		
l'I I		DOPRIL ⁻ imé pell		LATE TEVA 10 mg, ś	1	l '	1	1			
	1		4. TL	o procesileia a	7	Total am	nount:	1.00			
	<u>ır</u>	<u>iiportan</u> i	<u>ւ.</u> լո	e 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 (%)	0.20
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.80
Sig	nature and stamp Prescribing Doctor		ture and stamp Pharmacist