## **Medical Care Form**

Claim number:123

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
INOM,	Laura Marhysa 1978-01- 20		Agreed healthcare network:			
Carte ID:	594565					
	Laura Marhysa 1978-01- 20					
Age:	45.8		Prescribing Doctor / orientation: gfhg hgj ghg			
Marital Status :						
Gender :	Female					
edical Procedures:						
LOGE	Designation (Medical acts)		Coefficient	Rate	Total Cost	
	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status:  Gender:	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Age:  Gender:  Gender:  Female  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  594565  Full Name (first, middle, last):  Age:  45.8  Marital Status:  Gender:  Female  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Laura Marhysa 1978-01-20  Carte ID:  594565  Full Name (first, middle, last): 20  Age:  45.8  Prescribing Doctogfing hgj ghg  Marital Status:  Gender:  Female  Posignation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Laura Marhysa 1978-01-20  Carte ID:  594565  Full Name (first, middle, last):  Age:  45.8  Prescribing Doctor / orient gfhg hgj ghg  Marital Status:  Gender:  Female  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 Care		2. Pati Policy		3. Infos Referen Center	ice Medical	
<u>lmportan</u>	<u>t:</u> The validi	ty of this form cannot e	exceed 5 days	from the	Tota	al amount:
date of is	sue				To be paid by t	he patient
Assignment code				To be paid by the insurance company		-
			5. Det	ails Of Par	ramedical Procedu	ures:
Date	Code	Designation (Medical acts)		Coefficien	t Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5 da		exceed 5 days		Total amount:		
from the	date of issu	e		To be բ	paid by the patient	
Assignme	ent code			To be paid	d by the insurance company	
Patient	t signature	Signature and stamp medical Healthcare centre Doctor			d stamp of the	
One of the prescribed (Section Reserved For  The Prescribing  Doctor)  6. Medicines  Section Reserv  For The Pharmacist			ection Reserved t			
No: Drugs	5		Dosage	QuantityT	otal Cost	
ARIPIPRAZOLE SANDOZ 10 mg, comprimé orodispersible		é 0768	76867 4	50818		
	mportant: T	he prescribing	Total an	nount: 4	150818.00	

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 (%)	4067801.64
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	83016.36
Sig	nature and stamp Prescribing Doctor	Signat	ture and stamp Pharmacist