## **Medical Care Form**

Claim number: 64564

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
	ID obligatoire							
Access To Health Care		2. Patient	3. Infos Reference Medical Center					
Matricule:			Date and Time:					
Nom:	prashan 28	t kumar 1998-10-	Agreed healthcare network:					
Carte ID:	574372							
Full Name (first, middle, last):	prashan 28	t kumar 1998-10-						
Age:	24.8		Prescribing Doctor / orientation: 88 88 88					
Marital Status :								
Gender :	Male							
edical 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:  Carte ID:  Full Name (first, middle, prashan 28  Age:  Age:  Age:  Gender:  Male  Male	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Age:  24.8  Marital Status:  Gender:  Male  Mrite legibly  ID obligatoire  2. Patient Policy  Age:  24.8  Marital Status:  Male	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Age:  24.8  Marital Status:  Gender:  Male  Write legibly  ID obligatoire  3. Infos Reference Center  Agreed healthcare  Policy  Patient  Policy  Prescribing Docto 88 88 88  Male	Write legibly  ID obligatoire  2. Patient Policy  Matricule: Date and Time:  Nom:  Prashant kumar 1998-10-28  Carte ID: Full Name (first, middle, last): Age: Age: Age: Age: Age: Age: Age: Age			

<u>Important:</u> The validity of this form cannot	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 Refer Center	enc	e Medical			
Important: The validity of this form cannot excee					excee	d 5 days	from the		Т	otal	amount:
date of issue								To be paid by the patient			
Assi	gnmer	nt code	:			To be paid by the insurance company					
						5. Det	ails Of P	aram	nedical Proce	dur	es:
Date	Date Code Designation (Medical acts)			Coefficient		Rate	Т	otal Cost			
Important: The validity of this form cannot exceed			excee	d 5 days			Total amou	nt:			
from the date of issue					To be	e paid	d by the patie	ent			
Assignment code					To be paid by the insurance company						
Patient signature Signature and stamp medical Ho					ical Heal	Signature and stamp of the Doctor					
Prescribed (Section Reserved For Doctor)					The	dicines Section Reserved ribing For The Pharmacist			tion Reserved		
No:	Drugs	5				Dosage (	Quantity	Tota	l Cost		
1	BUCC	OLAM	10 mջ	g, solution buccale		10	l	1			
						Total am	nount:	1.00			
Important: The prescribing						1					

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	Signat	ture and stamp Pharmacist