Medical Care Form

Claim number:

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:	sourabl	n 2000-11-23	Agreed healthcare network:		
Carte ID:	123				
Full Name (first, middle, last):	sourabl	n 2000-11-23			
Age:	23.2		Prescribing Doctor / orientation: edwe wef wef		
Marital Status :					
Gender :	Male				
edical Procedures:					
Loge	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: Code 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: Age: 23.2 Prescribing Doctoedwe wef wef 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 / orientedwe wef wef 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 Referer Center	nce Medical		
		T								
<u>Important:</u> The validity of this form cannot exceed					exceed	l 5 days ⁻	from the		Tota	al amount:
date of issue								To be paid by the patient		
Assignment code						To be paid by the insurance company				
						5. Det	ails Of P	aram	edical Procedu	ıres:
Date Code Designation (Medical acts)		acts)		Coefficient		Rate	Total Cost			
Important: The validity of this form cannot exceed			exceed	l 5 days			Total amount			
from the date of issue				To be pa		e paic	l by the patient			
Assignment code						To be paid by the insurance company				
Patient signature Signature and stamp medical He					cal Heal	Signature and stamp of the Doctor				
Prescribed (Section Reserved For Doctor)			The	dicines Section Reserve ribing For The Pharmacist						
No:	Drug	5				Dosage (Quantity	Total	Cost	
1	1 buccolam 10 mg, solution buccale		2	20 2	200	4000	40000			
					-	Total am	ount:	4000	0.00	
Important: The prescribing		F								

Prescrib 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 (%)	40000.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist