## **Medical Care Form**

Claim number: 567567

h Insurance System Informa	Filling Instructions							
	Write legibly							
	ID obligatoire							
Access To Health Care		2. Patient	3. Infos Reference Medical Center					
Matricule:			Date and Time:					
Nom:	Lindsay	Laura 1973-02-12	Agreed healthcare network:					
Carte ID:	569161							
Full Name (first, middle, last):	Lindsay	<sup>,</sup> Laura 1973-02-12						
Age:	50.7		Prescribing Doctor / orientation: 675 67567 567					
Marital Status :								
Gender :	Female							
4. Details Of Medical Procedures:								
Lone	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, last):  Age:  Gender:  Gender:  Female  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Lindsay Laura 1973-02-12  Carte ID: 569161  Full Name (first, middle, last): Age: 50.7  Marital Status: Gender: Female  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Lindsay Laura 1973-02-12 Agreed healthcare  Carte ID:  Full Name (first, middle, last):  Age:  50.7  Prescribing Docto 675 67567 567  Marital Status :  Gender :  Female  Posignation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Lindsay Laura 1973-02-12 Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  50.7  Prescribing Doctor / orient 675 67567 567  Marital Status:  Gender:  Female  Pedical Procedures:  Code  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			3. Infos Referen Center	ice Medical		
Important: The validity of this form cannot exceed				exceed	d 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. Details Of Paramedical Procedures:						ıres:				
Date Code Designation (Medical acts)			Coefficient		Rate	Total Cost				
<u>Important:</u> 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 Tl			6. Med The Presci	dicines	Section Reserved For The Pharmacist					
No:	Drugs				Dosage		Quantity	Tota	otal Cost	
	aripiprazole sandoz 10 mg, comprimé orodispersible		3	3	9	9				
	1	nno et -	nt. Tl	o proceribina		Total an	nount:	9.00		
	<u>11</u>	<u>ııhnı ral</u>	<u></u> 111	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 (%)	8.82	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.18	
Sig	nature and stamp Prescribing Doctor	Signature and stamp Pharmacist		