Medical Care Form

Claim number: 5675

h Insurance System Informa	Filling Instructions				
	Write legibly				
	ID obligatoire				
Access To Health Care			3. Infos Reference Medical Center		
Matricule:			Date and Time:		
inom.	Laura M 20	larhysa 1978-01-	Agreed healthcare network:		
Carte ID:	594565				
	Laura M 20	larhysa 1978-01-			
Age:	45.8		Prescribing Doctor / orientation: 9o9o 9o9o 9o		
Marital Status :					
Gender :	Female				
edical Procedures:					
l ode	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: 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, laura Marhysa 1978-01-20 Age: 45.8 Prescribing Docto 9090 909 90 Marital Status: Gender: Female Pesignation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctor / orient 9090 9090 90 Marital Status: Gender: Female 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	ice Medical			
Important: The validity of this form cannot exceed				exceed	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 Pa	aram	nedical Procedu	ıres:	
Date Code Designation (Medical acts)			acts)		Coefficient Rate		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 T				6. Med The Presci	dicines	Section Reserved					
No:	Drugs					Dosage	Quantity	Tota	otal Cost		
	aripiprazole sandoz 10 mg, comprimé orodispersible			3	3	696					
			TI			Total an	nount:	696.0	00		
	<u>Ir</u>	<u>nportai</u>	<u>nτ:</u> Th	e prescribing	f			_			

Prescril each Doctor)	practitioner will bed (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 (%)	682.08
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	13.92
Sig	nature and stamp Prescribing Doctor	Signat	ture and stamp Pharmacist