## **Medical Care Form**

Claim number:23r23r

1. Health Insurance System Information		Filling Instructions				
SAM code:						
		ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule: rimary			Date and Time:			
Nom:	Prashar	nt 2000-10-10	Agreed healthcare network:			
Carte ID:						
	Prashar	nt 2000-10-10				
Age:	23.3		Prescribing Doctor / orientation: 23r 23r 23r			
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: Prashar  Carte ID:  Full Name (first, middle, last):  Age: 23.3  Marital Status:  Gender: Male  edical Procedures:  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Prashant 2000-10-10  Carte ID:  Full Name (first, middle, last): Age: 23.3  Marital Status:  Gender: Male  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare  Full Name (first, middle, last):  Age:  23.3  Prescribing Docto 23r 23r 23r  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Prashant 2000-10-10  Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  23.3  Prescribing Doctor / orien 23r 23r 23r  Marital Status:  Gender:  Male  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		ss To Health Care	2. Patient Policy			Infos Referen enter	ce Medica	I
Important: The validity of this form cannot exc		ceed 5 days from the		Total amount:				
date of issue					To be paid by the patient			
Assignment code				To be paid by the insurance company				
	5. Details Of Paramedical Procedures:							
Date	Code	Designation (Medical a	acts)	Coefficient		Rate	Total Cost	
<u>lmportant:</u> The validity of this form cannot ex from the date of issue		exceed 5 days			Total amount:			
		e		To be pa	paid by the patient			
Assignment code  To be paid by the insuranc compan			the insurance company					
Patient	Patient signature Signature and stamp medical Healthcare centre Doctor			the				
			6. Med	dicines				

Prescribed (Section Reserved For  Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist	
No:	Drugs	Dosage	Quantity	Total Cost	
1	perindopril tosilate teva 10 mg, comprimé pelliculé	20	20	200	

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist
2	aripiprazole sandoz 10 mg, comprimé orodispersible	10	10	100
	Important: The prescribing  practitioner will  indicate the duration of treatment for	Total amount:		300.00
each	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		0.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		300.00
Signature and stamp Prescribing Doctor			Signat	ture and stamp Pharmacist