## **Medical Care Form**

Claim number:1234

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:	Suyesh	15151 2023-09-02	Agreed healthcare network:		
Carte ID:	22				
Full Name (first, middle, last):	Suyesh	15151 2023-09-02			
Age:	0.3		Prescribing Doctor / orientation: sdxa sds dss		
Marital Status :					
Gender :	Male				
edical Procedures:					
l ode	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:  Carte ID:  Full Name (first, middle, last):  Age:  O.3  Marital Status:  Gender:  Male  Male  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Suyesh 15151 2023-09-02  Carte ID: 22  Full Name (first, middle, last): Age: 0.3  Marital Status:  Gender: Male  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Suyesh 15151 2023-09-02 Agreed healthcare  Carte ID:  Full Name (first, middle, last):  Age:  O.3  Prescribing Docto sdxa sds dss  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly    Dobligatoire

<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	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. 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 The			6. Med The Presci	dicines	For 1	Section Reserved For The Pharmacist					
No:	Drugs				Dosage		Quantity	Tota	Total Cost		
	aripiprazole sandoz 10 mg, comprimé orodispersible		23	23	529	529					
	1		nt. 71	o procesibir -		Total an	nount:	529.0	00		
	<u>ır</u>	<u>ııporta</u>	<u>ու.</u> In	e prescribing	ſ						

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 (%)	349.14
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	179.86
Sig	nature and stamp Prescribing Doctor	( Signat	cure and stamp Pharmacist