Medical Care Form

Claim number:f34rtf3w

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
	ID obligatoire						
Access To Health Care	2. Patient Policy		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: f34f 34f 34f				
Marital Status :							
Gender :	Female						
edical Procedures:							
LOGE	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender:	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, last): 20 Age: 45.8 Prescribing Docto f34f 34f 34f Marital Status: Gender: Female Posignation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctor / orient f34f 34f 34f Marital Status: Gender: Female 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 Referen enter	ce Medical		
<u>Impor</u>	tant: The	validit	y of this form cannot e	exceed 5 d	lays 1	from the		Tota	al amount:
date o	of issue							To be paid by t	he patient
Assignment code					To be paid by the insurance company			-	
				5.	. Det	ails Of Pa	aram	edical Procedu	ıres:
Date	Code	!	Designation (Medical acts)		Coefficie	Coefficient Rate		Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5		exceed 5 d	lays			Total amount:			
from t	the date o	of issue				To be	e paid	by the patient	
Assignment code			To be paid by the insurance company						
Pati	ient signa	ture	Signature and stamp medical Healthcare centre Doctor					d stamp of the	
Prescribed (Section Reserved For The				he	dicines	Section Reserved For The Pharmacist			
No: Dr	ugs			Dos	age(Quantity	Total	Cost	
perindopril tosilate teva 10 mg, comprimé pelliculé		né 32	3	32	1024				
	l			Tota	al am	nount:	1024	.00	
<u>Important:</u> The prescribing			1						

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 (%)	1003.52	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	20.48	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		