Medical Care Form

Claim number: 234

h Insurance System Informa	ation	Filling Instru	ctions		
SAM code:		Write legibly			
		ID obligatoire			
Access To Health Care			3. Infos Reference Center	e Medica	al
Matricule:			Date and Time:		
insured Nom: Pra		nt 1997-10-28	Agreed healthcare network:		
Carte ID:	234				
	Prashar	nt 1997-10-28			
Patient Age: 25.8			Prescribing Doctor / orientation: sdf sdf sdf		
Marital Status :					
Gender :	Male				
edical Procedures:					
Code	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: Prashar Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status: Gender: Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Carte ID: 234 Full Name (first, middle, last): Age: Age: 25.8 Prescribing Docto sdf sdf sdf Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Full Name (first, middle, last): Age: Age: 25.8 Prescribing Doctor / orien sdf sdf sdf Marital Status: Gender: Male 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. Pati Policy	ent	3. Infos Referen Center	ce Medical
•	idity of this form cannot e	exceed 5 days f	from the	Tota	al amount:
date of issue				To be paid by t	he patient
Assignment code				=	aid by the company
5. Details Of Paramedical Procedures:					ıres:
Date Code	Designation (Medical a	acts)	Coefficient	Rate	Total Cost
<u>lmportant:</u> The val	idity of this form cannot e	exceed 5 days		Total amount:	
from the date of issue			To be pa	id by the patient	
Assignment code			To be paid by the insurance company		
Patient signature Signature and stamp medical Hea		medical Heal	thcare centr	Signature and Doctor	l stamp of the
	6. Medicines				

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
	PARACETAMOL/CODEINE TEVA 500 mg/30 mg, comprimé pelliculé	10	1	1

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist	
2	LYRICA 300 mg, gélule	10	1	1	
	Important: The prescribing practitioner will indicate the duration of treatment for	Total amount:		2.00	
and	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		0.40	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		1.60	
	Signature and stamp Prescribing Doctor			ure and stamp Pharmacist	