Medical Care Form

Claim number: 234

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
		ID obligatoire					
Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:	Prashar	nt 1997-10-28	Agreed healthcare network:				
Carte ID:	234						
Full Name (first, middle, last):	Prashar	nt 1997-10-28					
Age:	25.8		Prescribing Doctor / orientation: asd asd asd				
Marital Status :							
Gender :	Male						
4. Details Of Medical Procedures:							
Lone	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: 234 Full Name (first, middle, last): Age: 25.8 Marital Status : Gender : Male Edical Procedures: 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 dical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Agreed healthcare Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Prescribing Docto asd asd asd Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 1997-10-28 Agreed healthcare networ Carte ID: 234 Full Name (first, middle, last): Age: Age: 25.8 Prescribing Doctor / orient asd asd asd Marital Status: Gender: Male Designation (Medical Coefficient Rate		

<u>Important:</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 Center	Referen	ce Medica	ıl	
Important: The validity of this form cannot exceed 5 days f				from the		Tota	l amount:		
date of issue					To be paid by the patient				
Assignment code						To be paid by the insurance company			
5. Details					ails Of Paraı	medical	Procedu	res:	
Date	Code		Designation (Medical a	acts)	Coefficient	Rate		Total Cost	:
Important: The validity of this form cannot exceed 5 days						Total a	amount:		
from the date of issue				To be paid by the patient					
Assignment code				To be paid l	be paid by the insurance company				
Patient signature Signature and stamp medical He			medical Heal	thcare centr	Signa e Docto		stamp of	the	

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

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist	
1/	EPINITRIL 5 mg/24 heures, dispositif transdermique	21	12	144	
-	PERINDOPRIL TOSILATE TEVA 10 mg, comprimé pelliculé	5	5	25	
eac	Important: The prescribing practitioner will indicate the duration of treatment for		mount:	170.00	
and		To be p the pat		34.00	
	its validity cannot exceed 72 hours after delivery	To be p MAADC		136.00	
	Signature and stamp Prescribing Doctor			ure and stamp Pharmacist	