Medical Care Form

Claim number: 32432

lth Insurance System Inforn	Filling Instructions						
SAM code:			Write legibly				
		ID obligatoire					
& Access To Health Care			3. Infos Reference Medical Cente				
Matricule:			Date and Time:				
Nom:	Dhiraj G.	2000-06-18	Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Dhiraj G.	2000-06-18					
Age:	23.4		Prescribing Doctor / orientation: asdsad asdsa sadsa				
Marital Status :							
Gender :	Male						
Medical Procedures:							
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Medical Procedures:	Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: Gender: Male Medical Procedures: Code Matricule: Dhiraj G. Dhiraj G. Dhiraj G. Dhiraj G. Dhiraj G. Dhiraj G. Dhiraj G.	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Marital Status: Gender: Male Medical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Marital Status: Gender: Male Medical Procedures: Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare network Carte ID: Full Name (first, middle, last): Age: 23.4 Prescribing Doctor / oriental asdsad asdsa sadsa Marital Status: Gender: Male Medical Procedures: Code Designation (Medical Coefficient Rate		

<u>Important:</u> The validity of this form cannot	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 Reference Medical Center					
Important: The validity of this form cannot exceed				d 5 days t	from the		Tota	l amount:		
date of issue						To be paid by the patient			ne patient	
Assignment code					To be paid by the insurance company					
	5. Details Of Paramedical Procedures:							ıres:		
Date Code Designation (Medical acts)				Coefficie	Coefficient Rate Total Cost					
<u>Important:</u> The validity of this form cannot exceed			d 5 days			Total amount:				
from the date of issue					To be	paid	by the patient			
Assignment code					To be pa	o be paid by the insurance company				
Patient signature Signature and stamp medica					ical Heal	thcare ce	entre	Signature and Doctor	l stamp of the	
Prescribed (Section Reserved For Doctor)			6. Med The Prescr	Section Reserved						
No:	Drugs	s Dosage (Quantity	Total Cost				
		imadol eg l.p. 200 mg, comprimé à ération prolongée			10	10	1230			
	_					Total an	nount:	1230.	00	
<u>Important:</u> The prescribing				 						

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 (%)	1230.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist