Medical Care Form

Claim number:111111111111111

| th Insurance System Inform | Filling Instructions | | | | | |
|-------------------------------------|--|--|---|---|--------------------------------|--|
| | Write legibly | | | | | |
| | ID obligatoire | | | | | |
| Access To Health Care | | | 3. Infos Reference | erence Medical Center | | |
| Matricule: | | | Date and Time: | | | |
| Nom: | Suyesh 1 | 15151 2023-09-02 | Agreed healthcare network: | | | |
| Carte ID: | 22 | | | | | |
| Full Name (first, middle, last): | Suyesh 1 | 5151 2023-09-02 | | | | |
| Age: | 0.3 | | Prescribing Doctor / orientation: daswaw asdas dse | | | |
| Marital Status : | | | | | | |
| Gender : | Male | | | | | |
| 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: edical Procedures: | Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male edical Procedures: Code Designation | 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: Designation (Medical | Write legibly ID obligatoire 2. Patient 3. Infos Reference Policy Matricule: Date and Time: Nom: Suyesh 15151 2023-09-02 Agreed healthcare Carte ID: 22 Full Name (first, middle, last): Suyesh 15151 2023-09-02 Age: 0.3 Prescribing Doctor daswaw asdas dse Marital Status: Gender: Male edical Procedures: Code Designation (Medical Coefficient | Write legibly D obligatoire | |

| <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. Ir | nfos Referenco | e Medical Center | | | |
|--|---|--------------|-------------------------|-----------------------|--|-------------------------------------|------------------|-----------------|------------|-----------|
| | | | | | | | | | | |
| <u>lmp</u> | ortant | <u>:</u> The | validit | y of this form cannot | exceed | d 5 days | from the | | Tota | l amount: |
| date of issue | | | | | | | Т | o be paid by th | ne patient | |
| Assignment code | | | | | | To be paid by the insurance company | | | - | |
| 5. Details Of Paramedical Procedures: | | | | | | | | | | |
| Dat | ate Code Designation (Medical acts) | | | Coefficient Rate | | Rate | Total Cost | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Important: 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 paid by the insurance company | | | | |
| Patient signature Signature and stamp medical Heal | | | | | Signature and stamp of the Doctor | | | | | |
| Prescribed (Section Reserved For Doctor) | | | 6. Med The Presci | dicines | Section Reserved For The Pharmacist | | | | | |
| No: | Drugs | | | | | Dosage | Quantity | Total | Cost | |
| | perindopril tosilate teva 10 mg, comprimé pelliculé | | | 3423 | 34 | 782 | 782 | | | |
| | _ | | . —- | | | Total am | nount: | 782.00 | 0 | |
| <u>Important:</u> The prescribing | | | | | | | | | | |

| Prescrib 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 (%) | 516.12 |
| | its validity cannot exceed 72 hours after delivery | To be paid by MAADO | 265.88 |
| Sigi | nature and stamp Prescribing Doctor | Signat | ture and stamp Pharmacist |