## **Medical Care Form**

Claim number: 34353

h Insurance System Informa	Filling Instructions				
	Write legibly				
	ID obligatoire				
Access To Health Care	2. Patient Policy		3. Infos Reference Medical Center		
Matricule:			Date and Time:		
Nom:	Dhiraj G	. 2000-06-18	Agreed healthcare network:		
Carte ID:	5677777	,			
Full Name (first, middle, last):	Dhiraj G	. 2000-06-18			
Age:	23.4		Prescribing Doctor / orientation: sada dsada adas		
Marital Status :					
Gender :	Male				
edical Procedures:					
l ode	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: 23.4  Marital Status: Gender: Male  Male  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Dhiraj G. 2000-06-18  Carte ID: 5677777  Full Name (first, middle, last): Age: 23.4  Marital Status: Gender: Male  Male  Male  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhiraj G. 2000-06-18  Agreed healthcare  Carte ID:  Full Name (first, middle, last):  Age:  23.4  Prescribing Doctor sada dsada adas  Marital Status:  Gender:  Male  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 / orient sada dsada adas  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate

<u>lmportant:</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			Infos Referend enter	ce Medical			
<u>Imp</u>	ortant	<u>:</u> The val	lidity	/ of this form cannot ε	exceed	l 5 days 1	from the		Tota	al amount:
date of issue								To be paid by the patient		
Assignment code						To be paid by the insurance company				
						5. Det	ails Of Pa	aram	edical Procedu	ıres:
Date Code Designation (Medical acts)			Coefficient Rate		Rate	Total Cost				
Important: The validity of this form cannot exceed			l 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 medic				ical Heal	ealthcare centre Doctor			d stamp of the		
Prescribed (Section Reserved For  Doctor)			6. Med The Prescr	Section Reserved For The Pharmacist						
No:	lo: Drugs Dosag			Dosage	Quantity	Total Cost				
	tracrium 25 mg/2,5 ml (1 pour cent), solution injectable en ampoule			34	4	12				
	_	_				Total an	nount:	12.00	)	
<u>Important:</u> The prescribing		L								

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 (%)	2.40
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	9.60
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist