## **Medical Care Form**

Claim number: 76567

| th Insurance System Inform          | Filling Instructions   |   |  |  |                               |  |  |  |  |
|-------------------------------------|--|---|--|--|-------------------------------|--|--|--|--|
|                                     | Write legibly  |   |  |  |                               |  |  |  |  |
|                                     | ID obligatoire   |   |  |  |                               |  |  |  |  |
| Access To Health Care               |  |   | 3. Infos Reference Medical<br>Center   |  |                               |  |  |  |  |
| Matricule:                          |  |   | Date and Time:   |  |                               |  |  |  |  |
| Nom:                                | Dhiraj G   | i. 2000-06-18   | Agreed healthcare network:   |  |                               |  |  |  |  |
| Carte ID:                           | 5677777  | ,   |  |  |                               |  |  |  |  |
| Full Name (first, middle,<br>last): | Dhiraj G   | i. 2000-06-18   |  |  |                               |  |  |  |  |
| Age:                                | 23.4   |   | Prescribing Doctor / orientation: sad dasda asdsd  |  |                               |  |  |  |  |
| Marital Status :                    |  |   |  |  |                               |  |  |  |  |
| Gender :                            | Male   |   |  |  |                               |  |  |  |  |
| 4. Details Of Medical Procedures:   |  |   |  |  |                               |  |  |  |  |
| K one                               | _  | tion (Medical   | Coefficient  | Rate   | Total<br>Cost                 |  |  |  |  |
|                                     |  |   |  |  |                               |  |  |  |  |
|                                     |  |   |  |  |                               |  |  |  |  |
|                                     | Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  Code  Code | Access To Health Care  Matricule:  Nom: Carte ID: Full Name (first, middle, last): Age: 23.4  Marital Status: Gender: Male  Designa | Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Dhiraj G. 2000-06-18  Carte ID: Full Name (first, middle, last): Age: 23.4  Marital Status: Gender: Male  dical Procedures:  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  Designation (Medical Coefficient | Write legibly    Dobligatoire |  |  |  |  |

| <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<br>Policy |                         |           | Infos Referend<br>Inter                | ce Medical |                |            |            |  |
|---|---|--|----------------------|-------------------------|-----------|--|------------|----------------|------------|------------|--|
|   |   |  |                      |                         |           |  |            |                |            |            |  |
| Important: The validity of this form cannot excee         |   |  |                      |                         | excee     | d 5 days                               | from the   |                | Tota       | il amount: |  |
| date of issue   |   |  |                      |                         |           | To be paid by the p                    |            |                | he patient |            |  |
| Assignment code   |   |  |                      |                         |           | To be paid by the insurance company    |            |                |            |            |  |
| 5. Details Of Paramedical Procedures:                     |   |  |                      |                         |           |  | ıres:      |                |            |            |  |
| Date Code Designation (Medical acts)                      |   |  | Coefficient Rate     |                         | 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 paid by the insurance company    |            |                |            |            |  |
| Patient signature Signature and stamp medical Hea         |   |  |                      |                         | ical Heal | Signature and stamp of the Doctor      |            |                |            |            |  |
| Prescribed (Section Reserved For The                      |   |  |                      | 6. Med<br>The<br>Presci | dicines   | Section Reserved<br>For The Pharmacist |            |                |            |            |  |
| No:   | Drugs   |  |                      | Dosage                  |           |  | Quantity   | Total Cost     |            |            |  |
|   | perindopril tosilate teva 10 mg, comprimé pelliculé |  |                      | 5 (                     | 55        | 4160                                   |            |                |            |            |  |
|   |   |  | 4. TI                |                         |           | Total am                               | nount:     | 4160.00        |            |            |  |
| <u>Important:</u> The prescribing                         |   |  |                      |                         |           |  | _          |                |            |            |  |

| Prescrik<br>each<br>Doctor) | practitioner will<br>ped (Section Reserved For<br>indicate the duration of treatment for<br>drug, | 6. Medicines The Prescribing     | Section Reserved<br>For The Pharmacist |
|-----------------------------|---|----------------------------------|--|
| and                         | this form is valid only for one pharmacy  | To be paid by<br>the patient (%) | 832.00                                 |
|                             | its validity cannot exceed 72 hours after delivery  | To be paid by<br>MAADO           | 3328.00                                |
| Sig                         | nature and stamp Prescribing Doctor   | Signat                           | ture and stamp Pharmacist              |