Medical Care Form

Claim number:

1. Health Insurance System Information			Filling Instructions					
	Write legibly							
		ID obligatoire						
Access To Health Care			3. Infos Reference Medical Center					
Matricule:			Date and Time:					
Nom:	Dhiraj G	5. 2000-06-18	Agreed healthcare network:					
Carte ID:								
Full Name (first, middle, last):	Dhiraj G	5. 2000-06-18						
Age:	23.4			r / orient	tation:			
Marital Status :								
Gender :	Male							
4. Details Of Medical Procedures:								
Loge	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: Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male Access To Health Care Marital Status: Dhiraj Carte ID: Dhiraj Car	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 Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto fwef wef wef 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 networ Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Doctor / orient fwef wef wef Marital Status: Gender: Male Pesignation (Medical Coefficient Rate			

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Information & Access To Health Care			2. Patient Policy			nfos Referen nter	ce Medica	ı	
<u>Important:</u> 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. Deta	ails Of Para	med	dical Procedu	res:	
Date	Code		Designation (Medical a	acts)	Coefficient	F	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5 da				exceed 5 days		Т	otal amount:		
from the date of issue			To be pa			y the patient			
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp medical Hea			medical Heal	thcare centr	~ I	Signature and Doctor	stamp of	the	
,									

	scribed (Section Reserved For	The	dicines	Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
	tramadol eg l.p. 200 mg, comprimé à libération prolongée	10	10	100

Prescribed (Section Reserved For Doctor)			dicines	Section Reserved For The Pharmacist	
2	gabapentine ranbaxy 400 mg, gélule	20	20	400	
	Important: The prescribing practitioner will indicate the duration of treatment for	Total amount:		500.00	
each	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		100.00	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		400.00	
Signature and stamp Prescribing Doctor			Signature and stamp Pharmacist		