## **Medical Care Form**

Claim number:

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 2	001-10-10	Agreed healthcare network:		
Carte ID:	32332				
Full Name (first, middle, last):	dhiraj 2	001-10-10			
Age:	22.3		Prescribing Doctor / orientation: wef wef wef		
Marital Status :					
Gender :	Male				
edical Procedures:					
Lone	Designation (Medical acts)		Coefficient	IRate	Total Cost
	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status:  Gender:  code	Access To Health Care  Matricule:  Nom: Carte ID: 32332  Full Name (first, middle, last): Age: 22.3  Marital Status: Gender: Male  Addical Procedures:  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: dhiraj 2001-10-10  Carte ID: 32332  Full Name (first, middle, last): Age: 22.3  Marital Status: Gender: Male  dical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  dhiraj 2001-10-10  Agreed healthcare  Full Name (first, middle, last):  Age:  22.3  Prescribing Doctowef wef wef  Marital Status:  Gender:  Male  Designation (Medical  Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  dhiraj 2001-10-10  Agreed healthcare networ  Carte ID:  32332  Full Name (first, middle, last):  Age:  Age:  22.3  Prescribing Doctor / orientwef wef wef  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate

<u>lmportant:</u> The validity of this form cannot e	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 Referer Center	nce Medical		
Important: The validity of this form cannot exceed				exceed	5 days	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	nedical Procedu	ures:
Date Code Designation (Medical acts)			acts)		Coefficient Rate		Rate	Total Cost		
Important: The validity of this form cannot exceed			exceed	5 days			Total amount			
from the date of issue				To be	e paic	l by the patient				
Assignment code					To be paid by the insurance company					
Patient signature Signature and stamp medical He					cal Heal	Signature and stamp of the Doctor				
Prescribed (Section Reserved For T			6. Med The Presci	dicines	Section Reserved For The Pharmacist					
No:	Drugs		Dosage			Quantity	Tota	Total Cost		
	aripiprazole sandoz 10 mg, comprimé orodispersible		10	10	100					
	1		nt. Tl	o procesibir -		Total an	nount:	100.	00	
	<u>ır</u>	<u>nporta</u>	<u>nτ:</u> In	e 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 (%)	20.00	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	80.00	
Sig	nature and stamp Prescribing Doctor	Signature and stamp Pharmacist		