## **Medical Care Form**

Claim number:34f3e4f

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
SAM:			ID obligatoire					
Access To Health Care	2. Patient Policy		3. Infos Reference Medical Center					
Matricule:			Date and Time:					
INOM,	Laura M 20	larhysa 1978-01-	Agreed healthcare network:					
Carte ID:	594565							
	Laura M 20	larhysa 1978-01-						
Age:	45.8		Prescribing Doctor / orientation: fsdf sdf 4fewe					
Marital Status :								
Gender :	Female							
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:  594565  Full Name (first, middle, laura Natura N	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  594565  Full Name (first, middle, last):  Age:  45.8  Marital Status :  Gender :  Female  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Laura Marhysa 1978-01-20  Carte ID:  594565  Full Name (first, middle, laura Marhysa 1978-01-20  Age:  45.8  Prescribing Doctofsdf sdf 4fewe  Marital Status:  Gender:  Female  Pesignation (Medical  Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Laura Marhysa 1978-01-20  Carte ID:  594565  Full Name (first, middle, last):  Age:  45.8  Prescribing Doctor / orient fsdf sdf 4fewe  Marital Status:  Gender:  Female  Pesignation (Medical Coefficient Rate			

<u>Important:</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 Referen Center	ce Medical		
<u>Impo</u>	<u>rtant:</u> The	validit	y of this form cannot e	exceed 5 da	ys 1	from the		Tota	al amount:
date	of issue							To be paid by t	he patient
Assignment code					To be paid by the insurance company			-	
5. Details Of Paramedical Procedures:						ıres:			
Date	Code	de Designation (Medical acts)		Coefficie	Coefficient Rate		Total Cost		
<u>Important:</u> The validity of this form cannot exceed 5 d		exceed 5 da	ys			Total amount:			
from	the date (	of issue	2			To be	e paid	d by the patient	
Assignment code			To be paid by the insurance company						
Pat	tient signa	ature	Signature and stamp medical Healthcare centre Doctor					d stamp of the	
6. Med Prescribed (Section Reserved For The Prescri					Section Reserved For The Pharmacist				
No: D	rugs			Dosa	ge	Quantity	Tota	l Cost	
perindopril tosilate teva 10 mg, comprimé pelliculé		né 21		12	252	252			
-				Total	am	nount:	252.0	00	
<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 (%)	246.96	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	5.04	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		