Medical Care Form

Claim number:

th Insurance System Inforr	Filling Instructions					
	Write legibly					
		ID obligatoire	ligatoire			
Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:	Dhiraj G. ː	2000-06-18	Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Dhiraj G. ː	2000-06-18				
Age:	23.4		Prescribing Doctor / orientation: werewr ewrew ewrew			
Marital Status :						
Gender :	Male					
ledical Procedures:						
Code	Designati acts)	on (Medical	Coefficient	Rate	Total Cost	
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: ledical Procedures:	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male Male Male Designati	Mrite 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 Male Medical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare in Prescribing Doctor in Werewr ewrew ewrey were wrew ewrey. 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 / oriental werewr ewrew Marital Status: Gender: Male Designation (Medical Coefficient Rate	

<u>lmportant:</u> The validity of this form canno	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 Reference Medical Center					
Important: The validity of this form cannot exceed			d 5 days	from the		Tota	l amount:			
date of issue					To be paid by the patient					
Assignment code				To be paid by the insurance company						
						5. Det	ails Of Pa	arame	edical Procedu	ıres:
Date	Date Code Designation (Medical acts)			Coefficient Rate		Rate	Total Cost			
<u>Important:</u> The validity of this form cannot exceed			d 5 davs			Total amount:				
from the date of issue				To be	paid	by the patient				
Assignment code				To be pa	paid by the insurance company					
Patient signature Signature and stamp medic			ical Heal	thcare ce	ntre	Signature and Doctor	d stamp of the			
Prescribed (Section Reserved For Doctor)			6. Med The Presci	For The Pharmacist		ction Reserved t				
No: Drugs		Dosage	Quantity	Total Cost						
1	aripiprazole sandoz 10 mg, comprimé orodispersible			10	1220					
Н	O Odispersione			Total an	nount:	1220.00				
	Important: The 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 (%)	1170.00	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	50.00	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		