Medical Care Form

Claim number:8888

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:	Lindsay	Laura 1973-02-12	Agreed healthcare network:					
Carte ID:	569161							
Full Name (first, middle, last):	Lindsay	Laura 1973-02-12						
Age:	50.7		Prescribing Doctor / orientation: yu iyui yui					
Marital Status :								
Gender :	Female							
4. Details Of Medical Procedures:								
LOGE	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: Full Name (first, middle, last): Age: Gender: Gender: Female Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Lindsay Laura 1973-02-12 Carte ID: 569161 Full Name (first, middle, last): Age: 50.7 Marital Status: Gender: Female edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Lindsay Laura 1973-02-12 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: So.7 Prescribing Docto yu iyui yui Marital Status : Gender : Female Policy Caefficient Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Lindsay Laura 1973-02-12 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Age: 50.7 Prescribing Doctor / orient yu iyui yui Marital Status: Gender: Female Pedical Procedures: Code 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. Details Of Paramedical Procedures:						ıres:				
Date Code Designation (Medical acts)		acts)		Coefficient		Rate	Total Cost			
<u>Important:</u> 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 Hea					cal Heal	Signature and stamp of the Doctor				
Prescribed (Section Reserved For The			6. Med The Prescr	dicines	For 1	Section Reserved For The Pharmacist				
No:	Drugs				Dosage(Quantity	Tota	otal Cost	
		razole s persibl		z 10 mg, comprimé	,	1	1	1		
	1		nt. Tl	o puossuibin s		Гotal am	nount:	1.00		
	<u>Ir</u>	<u>nportai</u>	<u>nτ:</u> Th	e prescribing	I			_		

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 (%)	0.98
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.02
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist