Medical Care Form

Claim number:gtgtg

| 1. Health Insurance System Information | | Filling Instructions | | | | |
|--|--|--|---|---|---|--|
| SAM code: | | | ibly | | | |
| SAM: | | | toire | | | |
| Information & Access To Health Care | | | 3. Infos Reference Medical Center | | | |
| Matricule: | | | Date and Time: | | | |
| Nom: | Eric dwo | ed 2023-06-20 | Agreed healthcare network: | | | |
| Carte ID: | 444 | | | | | |
| Full Name (first, middle, last): | Eric dw | ed 2023-06-20 | | | | |
| Age: | 0.3 | | Prescribing Doctor / orientation: grg rgrg rgrg | | | |
| 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: Eric dw Carte ID: 444 Full Name (first, middle, last): Age: 0.3 Marital Status : Gender : Male edical Procedures: Code Designa | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Eric dwed 2023-06-20 Carte ID: 444 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Male edical Procedures: Code Designation (Medical | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Eric dwed 2023-06-20 Agreed healthcare Carte ID: 444 Full Name (first, middle, last): Age: 0.3 Prescribing Docto grg rgrg rgrg Marital Status: Gender: Male Designation (Medical Coefficient | Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Eric dwed 2023-06-20 Agreed healthcare networ Carte ID: 444 Full Name (first, middle, last): Age: O.3 Prescribing Doctor / orient grg rgrg rgrg Marital Status: Gender: Male Designation (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 | | | Infos Referen enter | ce Medica | I | |
|--|---------------------------------------|------------------------|---------------|---------------|-------------------------------------|---------------------------|------------|--|
| | | | | | | | | |
| <u>Important:</u> The validity of this form cannot e | | exceed 5 days from the | | Total amount: | | | | |
| date of issue | | | | | | To be paid by the patient | | |
| Assignment code | | | | | To be paid by the insurance company | | | |
| | 5. Details Of Paramedical Procedures: | | | | | | | |
| Date | Code | Designation (Medical a | acts) | Coefficient | | Rate | Total Cost | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Important: The validity of this form cannot exce | | | exceed 5 days | | | Total amount: | | |
| from the date of issue | | | To be pa | | aid | by the patient | | |
| Assignment code To be paid | | | To be paid | by | the insurance company | | | |
| Patient signature Signature and stamp medical Healthcare cer | | | thcare cent | re | Signature and Doctor | stamp of | the | |
| 6. Medicines | | | | | | | | |

| Prescribed (Section Reserved For Doctor) | | 6. Medicines The Prescribing | | Section Reserved For The Pharmacist |
|---|--|------------------------------|----------|--|
| No: | Drugs | Dosage | Quantity | Total Cost |
| 1 | perindopril tosilate teva 10 mg, comprimé pelliculé | 2 | 1 | 1 |

| Prescribed (Section Reserved For Doctor) | | 6. Medicines The Prescribing | | Section Reserved For The Pharmacist |
|--|---|-------------------------------------|----|--|
| 2 | gabapentine ranbaxy 400 mg, gélule | 34 | 34 | 34 |
| | Important: The prescribing practitioner will indicate the duration of treatment for | Total amount: | | 35.00 |
| and | drug, this form is valid only for one pharmacy | To be paid by the patient (%) | | 23.10 |
| | its validity cannot exceed 72 hours after delivery | To be paid by MAADO | | 11.90 |
| Signature and stamp Prescribing Doctor | | ો Signature and stamp Pharmacist | | |