Medical Care Form

Claim number:4654

h Insurance System Informa	Filling Instructions				
	Write legibly				
	ID obligatoire				
Access To Health Care			3. Infos Reference Medical Center		
Matricule:			Date and Time:	e:	
Nom:	Prashar	nt 1997-10-28	Agreed healthcare network:		
Carte ID:	234				
Full Name (first, middle, last):	Prashar	nt 1997-10-28			
Age:	25.8		Prescribing Doctor / orientation: 45 345 345		
Marital Status :					
Gender :	Male				
edical Procedures:					
Code	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: Prashar Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status: Gender: Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Carte ID: 234 Full Name (first, middle, last): Age: Age: 25.8 Prescribing Docto 45 345 345 Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Agreed healthcare netword Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Prescribing Doctor / orien 45 345 345 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 excee				exceed	5 days 1	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 Procedi	ures:
Date Code Designation (Medical acts)		acts)		Coefficient		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 Hea					cal Heal	Signature and stamp of the Doctor				
Prescribed (Section Reserved For The				6. Med The Prescr	dicines	Section Reserved For The Pharmacist				
No:	Drugs					Dosage Quantity Total Cost			l Cost	
I'I I		DOPRIL ⁻ imé pell		LATE TEVA 10 mg, ś	1	l '	1	1		
	1		4. TL	o procesibile =	7	Total am	nount:	1.00		
	<u>ır</u>	<u>iiportan</u> i	<u>ւ.</u> լո	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 (%)	0.20
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.80
Sig	nature and stamp Prescribing Doctor		ture and stamp Pharmacist