

RECOMMANDATIONS IMPORTANTES A LIRE POUR ACTIVER LES REMBOURSEMENTS ET EVITER LES REJETS

Conditions générales :

- Le cadre réservé à l'adhérent doit être dûment renseigné.
- Le cadre réservé au médecin doit être renseigné par le praticien lui-même notamment la nature de la maladie.
- La validité de la feuille de soins est limitée à 3 mois à compter de la première consultation.
- L'entente préalable est exigée pour toute hospitalisation médicale, chirurgicale, soins dentaires spéciaux, extractions multiples, parodontie orthodontie, prothèses dentaires, prothèses auditives ou orthopédiques ainsi que pour tous les actes effectués en série.
- En cas d'accident, une déclaration précisant les causes et circonstances de l'accident est à joindre à la feuille de soins.

Pharmacie :

- Les vignettes des médicaments doivent être obligatoirement jointes aux ordonnances.
- Pour les médicaments sans vignettes une facture de la pharmacie doit être jointe.

Radiologie et Biologie :

- La facture ainsi qu'une copie des résultats des analyses ou du compte rendu (sous pli confidentiel) doivent être jointes à l'ordonnance médicale pour toute demande de remboursement.
- Un pli confidentiel du médecin prescripteur des analyses ou radios peut être demandé par le médecin conseil de la mutuelle.

Optique :

- L'ordonnance du médecin prescripteur et la facture de l'opticien sont à joindre à la feuille de soins.

Rééducation :

- L'entente préalable renseignée par le médecin prescripteur est exigée avant le début des séances de rééducations.
- Pour le remboursement, la facture et le calendrier des séances effectuées sont à joindre à la feuille de soins.

Dentaire :

- En cas de prothèses ou de traitement canalaires, l'accord préalable renseigné sur la feuille de soins est obligatoire avant le début de traitement.
- La facture doit être jointe à la feuille de soins pour toute demande de remboursement.
- La radio-après soins est obligatoire en cas de prothèses ou de traitement canalaires.

Maladie et Affection Longue Durée ALD et ALC :

- La déclaration de maladie chronique doit être renseignée par le médecin prescripteur et renouvelée tous les 6 mois.

Adresses Mails utiles

- | | |
|------------------------------------|-----------------------|
| 0 Réclamation | : contact@mupras.com |
| 0 Prise en charge | : pec@mupras.com |
| 0 Adhésion et changement de statut | : adhesion@mupras.com |

La MUPRAS garantit le respect de la loi n° 09-08 relative à la protection des personnes physiques à l'égard du traitement des données à caractère personnel.

MUPRAS : Centre Allal Ben Abdellah - 6ème Etage Angle Rue Mohamed Fakir et Rue Allal Ben Abdellah - Quartier de l'Horloge Casablanca 20000 - Tél. : 05 22 20 45 45 (LG) - Fax : 05 22 22 78 18 - www.mupras.com



Déclaration de Maladie

N° W21-788054

Maladie

Dentaire

Optique

Autres

Cadre réservé à l'adhérent (e)	Société :	
Matricule : <u>1002</u>	<u>153368</u>	
<input type="checkbox"/> Actif	<input checked="" type="checkbox"/> Pensionné(e)	<input type="checkbox"/> Autre :
Nom & Prénom : <u>AJAL OTMANE</u>		
Date de naissance :	<u>1948</u>	
Adresse :	<u>95 RUE OURJOUANE APT 5 1104 RABTA CASA</u>	
Tél. :	<u>061253331</u>	
Total des frais engagés :		<u>152,25</u> Euros

Autorisation CNDP N° : A-A-215/2019

Cadre réservé au Médecin

Cachet du médecin :

Date de consultation :	<u>15 MAR. 2023</u>
Nom et prénom du malade :	<u>ABDELLAH BEN ALLAL</u>
Age :	<u>75</u>

Lien de parenté : Lui-même

Conjoint

Enfant

Nature de la maladie :

En cas d'accident préciser les causes et circonstances :

Dans le cas où la maladie aurait un caractère confidentiel, communiquer les renseignements sous pli confidentiel à l'attention du médecin conseil de la Mutuelle.

J'atteste sur l'honneur l'exactitude des renseignements portés sur la présente déclaration. Je déclare avoir pris connaissance de la clause relative à la protection des données personnelles.

Fait à :

Le : 15 MAR. 2023

Signature de l'adhérent(e) :



RELEVE DES FRAIS ET HONORAIRES

Dates des Actes	Natures des Actes	Nombre et Coefficient	Montant détaillé des Honoraires	Cachet et signature du Médecin attestant le Paiement des Actes
				INP : <input type="text"/>

225 ACE
ENDE ALAR
LEUDON CELLE
:01 46 30 24 06
Sarrols 37165
SARROLA
SARROLA
SARROLA

~~EXÉCUTION DES ORDONNANCES~~

Date	Montant de la Facture
17/02/23	159,75
PH	

MARSEL
CELESTE
ADORE
ZAGREB
2016

ANALYSES - RADIOGRAPHIES

Cachet et signature du Laboratoire et du Radiologue	Date	Désignation des Coefficients	Montant des Honoraires

AUXILIAIRES MEDICAUX

Cachet et signature du Particien	Date des Soins	Nombre				Montant détaillé des Honoraires
		AM	PC	IM	IV	

RELEVE DES FRAIS ET HONORAIRES

Le praticien est prié de préciser la dent traitée, l'acte pratiqué en indiquant la nature des soins.

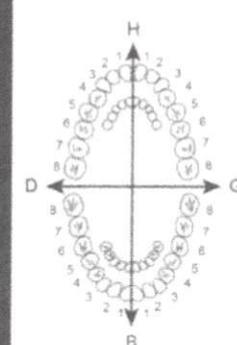
Important :

Veuillez joindre les radiographies en cas de prothèses ou de traitement canalaires, ainsi que le bilan de l'ODF

O.D.F
PROTHESES DENTAIRES

DETERMINATION DU CŒFFICIENT MASTICATOIRE

H
25533412 21433552
00000000 00000000
D 00000000 00000000
35533411 11433553



[Création, remont, adjonction]

Fonctionnel. Thérapeutique, nécessaires à la profession.

O.D.F PROTHESES DENTAIRES	DETERMINATION DU COEFFICIENT MASTICATOIRE	COEFFICIENT DES TRAVAUX																
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VISA ET CACHET DU PRATICIEN ATTESTANT LE DEVIS

VISA ET CACHET DU PRATICIEN ATTESTANT L'EXECUTION

PHARMACIE AMAR SÉLARL
 Gad AMAR
 15 avenue de Celle
 92360 MEUDON LA FORET
 FRANCE
 Tel: 0146307416
 N° SIRET: 80785248800020
 Code NAF: 4773Z - FR60807852488

Page

1 / 1

FACTURE

N°9015

Du 18/02/2023

Date de l'échéance 19/02/2023

AJAL OTMANE
 10 rue du docteur Bourrier
 91600 SAVIGNY SUR ORGE

Opérateur: ZAYNA K

Désignation Code produit	Qté	PUHT	Taux TVA	Montant Total HT
ELIQUIS 5MG CPR BT 60 3400926784102	2	57,738	2,10%	115,48
Honor. dispens. HD7	2	0,999	2,10%	2,00
FORXIGA 10MG CPR 30X1 3400926649975	1	37,502	2,10%	37,50
Honor. dispens. HD7	1	0,999	2,10%	1,00

Montant HT	Taux TVA (*)	Montant TVA	Montant TTC
155,98	2,1% (4)	3,28	159,25
Total HT		Total TVA	Total TTC
155,98		3,28	159,25

Mode(s) de règlement

CB

159,25

Reste dû

0,00

Montants exprimés en Euros

Membre d'un centre de gestion agréé par l'administration fiscale, acceptant à ce titre les règlements par chèques libellés à son nom

pharmacie-amar0521@orange.fr
 FAX : 01 46 30 37 55
 TEL : 01 46 30 74 16
 92360 MEUDON LA FORET
 15 AVENUE DE CELLE

(u) indique les quantités unitaires

(*) Les codes TVA: code 4: taux 2.1

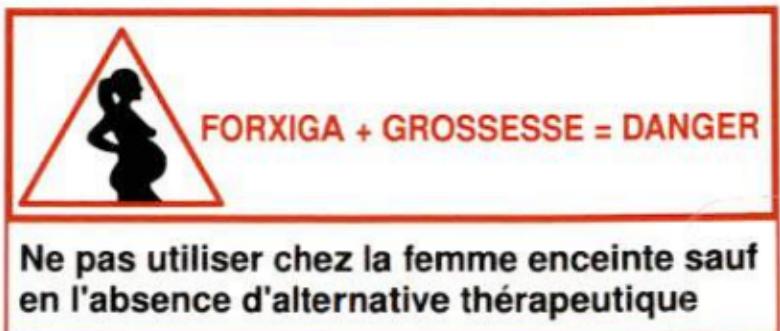
PHARMACIE AMAR SÉLARL

(NF525) 126//1/FACTURATION/FACTURE/UcNQ/N/QFOM/N/MYMN/2.15.1.3.R10-112/B525/0370-1/755648

FRANCE

RESPECTER LES DOSES PRESCRITES

Liste I – Uniquement sur ordonnance
Médicament autorisé n°
34009 266 499 7 5



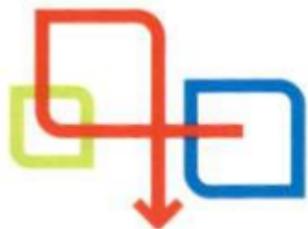
ETUI EN CARTON
+ NOTICE
+ PLAQUETTE VIDE



Séparez les éléments avant de trier



Exploitant :
AstraZeneca
Tour Carpe Diem
31 place des Corolles
92400 COURBEVOIE



forxiga[®]

dapagliflozine

30 x 1 comprimés pelliculés

Voie orale

10 mg

comprimés
pelliculés

AstraZeneca

TAYX

10-2025

PC : 03400926649975

SN : 00608248145946



PC
SN
Lot
EXP

03400926784102
1669460904666
6M6105
07/2025



FRANCE

RESPECTER LES DOSES PRESCRITES

Liste I - Médicament autorisé n° 34009

26784102

Uniquement sur ordonnance



3400926784102

PC
SN
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1669460904666
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FRANCE

RESPECTER LES DOSES PRESCRITES

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Uniquement sur ordonnance



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