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

- Réclamation : contact@mupras.com
- Prise en charge : pec@mupras.com
- 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'Horlo... Casablanca 20000 - Tél. : 05 22 20 45 45 (LG) - Fax : 05 22 22 78 18 - www.mupras.com

MUPRAS
Mutuelle de Prévoyance & d'Actions Sociales de Royal Air Maroc

Déclaration de Maladie

Nº W21-806937

172080

☒ Maladie ☐ Dentaire ☐ Optique ☐ Autres

Cadre réservé à l'adhérent(e)

Matricule : 3183 Société :

☐ Actif ☒ Pensionné(e) ☐ Autre :

Nom & Prénom : EL AYRANI Jouiéy Abdellah

Date de naissance : 11/21/1953

Adresse : VILLA 7 Lotissement TOURIA Boulevard CENTRE CASA

Tél. 0661525001 Total des frais engagés : 1934 ⁴⁴ Dhs

Cadre réservé au Médecin

Cachet du médecin : MUPRAS S.M.R. 17 AOUT 2023 ACCUEIL

Date de consultation : /

Nom et prénom du malade : Age:

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 ... données personnelles.

Autorisation CNDP N° : A-A-215/2019

RELEVE DES FRAIS ET HONORAIRES

Dates des Actes	Natures des Actes	Nombre et Cœfficient	Montant détaillé des Honoraires	Cachet et signature du Médecin attestant le Paiement des Actes
5/5/2023	SOINS hospitaliers			INP :
6/5/2023	SOINS de consultation			

EXECUTION DES ORDONNANCES

Cachet du Pharmacien ou du Fournisseur	Date	Montant de la Facture

ANALYSES - RADIOGRAPHIES

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

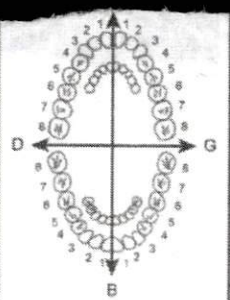
AUXILIAIRES MEDICAUX

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

VOLET ADHERENT

*** Il est entendu que le réglement est conditionné par la fourniture de tous les justificatifs exigés par la Mutuelle.**

[redacted]

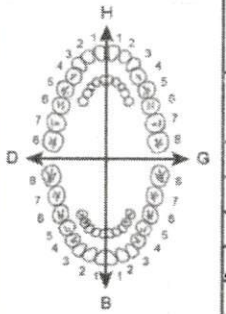


MONTANTS DES SOINS

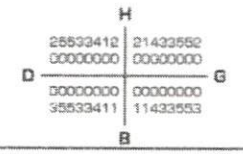
DEBUT D'EXECUTION

FIN D'EXECUTION

O.D.F
PROTHESES DENTAIRES



DETERMINATION DU CŒFFICIENT MASTICATOIRE



(Création, remont, adjonction)
Fonctionnel, Thérapeutique, nécessaire à la profession

CŒFFICIENT DES TRAVAUX

MONTANTS DES SOINS

DATE DU DEVIS

DATE DE L'EXECUTION

VISA ET CACHET DU PRATICIEN ATTESTANT LE DEVIS

VISA ET CACHET DU PRATICIEN ATTESTANT L'EXECUTION

Northwell Health Physician Partners

LB#8253, P.O. Box 95000
Philadelphia, PA 19195-0001
DEPARTMENT / SPECIALTY OF EMERGENCY MEDICINE

This is a bill
Statement date: 06/27/2023

Please turn page over for your summary of care

Patient name: ABDELILAH ELAMRANIJOUTEY
Guarantor name: ABDELILAH ELAMRANIJOUTEY

This is a bill - Please pay the full amount due using one of the methods below.

Your insurance has been billed

Amount due	**$1,934.00**
Due date	**07/12/23**
Account number	**23563137-3**

The amount due represents your cost-sharing responsibility as directed by your insurance company and for your specific plan.

Pay online

Make fast and easy payments at www.northwell.edu/billpay

or

Scan this QR code with your phone's camera.

Pay by mail

Mail your check with the payment coupon below. Please include the bill account number on check.

Make Checks Payable to:

NSLIJ MEDICAL PC
P.O. BOX 28372
NEW YORK, NY 10087-8372

Pay by phone

Call 855-571-5843 to speak to a payment specialist.

Hours of Operation:

Monday - Thursday: 9am - 4:45pm
Friday: 8am - 3:45pm.

Have questions related to your bill? Visit www.northwell.edu/billpay or email us at PhysicianUpdates@northwell.edu.
For your protection, please do not email credit card or payment information.

Your feedback is important: Tell us how we're doing with a short, confidential survey at redcap.link/billpay

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Northwell Health Physician Partners

LB#8253, P.O. Box 95000
Philadelphia, PA 19195-0001

Statement date: 06/27/23 | Amount due: $1,934.00
Due date: 07/12/23 | Account Number: 23563137-3

☐ **Has your insurance changed?** Check this box and view the "Change of insurance information" section on the back.

If paying by credit card, please fill out below:

Name on card _____

Card number _____

Expiration date _____ Amount _____

Signature _____

ABDELILAH ELAMRANIJOUTEY
53 SOMMER AVE
STATEN ISLAND NY 10314-3313

NSLIJ MEDICAL PC
P.O. BOX 28372
NEW YORK, NY 10087-8372

2356313700300193400000200131 5

Northwell Health Physician Partners
LB#8253, P.O. Box 95000
Philadelphia, PA 19195-0001
DEPARTMENT / SPECIALTY OF EMERGENCY MEDICINE
Patient name: ABDELILAH ELAMRANIJOUTEY

This is a bill
Statement date: 06/27/2023

Summary of care

Provider Name: KONG MD,RODRIGO I **Invoice Number:** 115140770		**Primary Insurance:** MEDICAID/EMERGENCY MCAID ONLY **Secondary Insurance:** None Provided
Date	**Service**	**Amount**
05/05/23	99223 INITIAL HOSPITAL CARE	
Amount Approved by Your Insurance		**$1,270.00**
Payments		
Patient Payments		$0.00
Amount Due:		**$1,270.00**

Provider Name: REYES DO,JENNIFER ASHLEY **Invoice Number:** 115140771		**Primary Insurance:** MEDICAID/EMERGENCY MCAID ONLY **Secondary Insurance:** None Provided
Date	**Service**	**Amount**
05/06/23	99233 SBSQ OBSERVATION CARE	
Amount Approved by Your Insurance		**$664.00**

Continued on next page

More billing resources

FAQs
Visit us online at northwell.edu/help/billing

Copay, deductible, co-insurance, claim denial, coverage
Please contact your insurance provider for more details.

Payment plans
If you're unable to pay in full, you may be eligible for a payment plan. Call 855-571-5843 for information.

Financial assistance
Financial Assistance: Please contact us online at northwell.edu/financial-assistance or by phone at 800-995-5727.

Support
Email PhysicianUpdates@northwell.edu or call 855-571-5843.

Change of insurance information

Let us know your new insurance information. Email changes to PhysicianUpdates@northwell.edu, call us at (516) 876-5555 or fill out the form below.

Insurance coverage: ☐ Primary ☐ Secondary ☐ Other: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Co. Name _____ Phone # _____

Policy Holder's Name _____ Birth Date _____

Insurance ID _____ Group # _____

Please apply the changes above to the following dates of service _____

Northwell Health Physician Partners
LB#8253, P.O. Box 95000
Philadelphia, PA 19195-0001
DEPARTMENT / SPECIALTY OF EMERGENCY MEDICINE

This is a bill
Statement date: 06/27/2023

Patient name: ABDELILAH ELAMRANIJOUTEY

Summary of care (Cont.)

Payments	
Patient Payments	$0.00
Amount Due:	**$664.00**

Name: ABDELILAH EL AMRANI JOUTEY
Date of Birth: 01-Dec-1953
Gender Identity: Male

Documents

5/6/2023Sandy Ibrahim, PA - Order Reconciliation
Reconciliation Type: Admission Reconciliation requested on behalf of Ibrahim, Sandy (Physician Assistant) done by Ibrahim, Sandy (PA)
Admission Reconciliation - Partial Reconciliation: 06-May-2023 16:33 by: Ibrahim, Sandy (PA)
Admission Reconciliation - Reconciliation: 06-May-2023 17:36 by: Ibrahim, Sandy (PA)

Home Medications	Entered	Last Dose Taken	Reconciled with current Order	Reconciliation Comment/ Additional Information
aspirin 81 mg oral capsule 1 orally once a day	06-May-2023			Reviewed and Reconciled
~~atorvastatin 80 mg oral tablet 1 orally once a day~~	06-May-2023			**NoLongerTaking**
canagliflozin 300 mg oral tablet 1 orally once a day	06-May-2023			Reviewed and Reconciled
Crestor 40 mg oral tablet 1 orally once a day	06-May-2023			Reviewed and Reconciled
insulin detemir 100 units/mL subcutaneous solution 22 unit(s) subcutaneous once a day (at bedtime)	06-May-2023			Reviewed and Reconciled
Janumet 50 mg-500 mg oral tablet 1 orally 2 times a day	06-May-2023			Reviewed and Reconciled
levothyroxine 50 mcg (0.05 mg)/mL oral solution 1 orally once a day	06-May-2023			Reviewed and Reconciled
losartan 50 mg oral tablet 1 orally once a day	06-May-2023			Reviewed and Reconciled
~~metFORMIN 500 mg oral tablet 1 orally once a day~~	06-May-2023			**NoLongerTaking**
Plavix 75 mg oral tablet 1 orally once a day	06-May-2023			Reviewed and Reconciled
~~Tradjenta 5 mg oral tablet 1 orally once a day~~	06-May-2023			**NoLongerTaking**

Documentation of outpatient medication history is incomplete.

Additional Current Orders

aspirin chewable 81 milliGRAM(s), Oral, dailyAdministration Instructions: This is a High Alert Medication.Provider's Contact #: (718) 226-3401

atorvastatin [Known as LIPITOR]80 milliGRAM(s), Oral, at bedtime

clopidogrel Tablet [Ordered as PLAVIX]75 milliGRAM(s), Oral, dailyIndication: pts medAdministration Instructions: This is a High Alert Medication.Provider's Contact #: (718) 226-3401

dextrose 5%. Solution, 1000 milliLiter(s) infuse at 100 mL/HrSpecial Instructions: Hypoglycemia Treatment. Conditional Order: Run dextrose 5% water at 100 milliLiters/hour and NOTIFY PROVIDER; recheck Blood Glucose Level EVERY 15 to 30 minutes until BLOOD GLUCOSE LEVEL GREATER THAN 100 milliGRAM(s)/deciLiter. 1. IF BLOOD GLUCOSE GREAT

~~dextrose 5%. Solution, 1000 milliLiter(s) infuse at 50 mL/HrSpecial Instructions: Hypoglycemia Treatment. Conditional Order: Run dextrose 5% water at 50 milliLiter(s)/hour and NOTIFY PROVIDER; recheck blood glucose level EVERY 15 to 30 minutes until blood glucose level GREATER THAN OR EQUAL TO 100 milliGRAM(s)/deciLiter~~

dextrose 50% Injectable 12.5 Gram(s), IV Push, once, Stop After 1 DosesSpecial Instructions: Hypoglycemia Treatment. Conditional Order: Administer dextrose 50%, 12.5 Gram(s) IV Push STAT, for Patient blood glucose level 50-69 milliGRAM(s)/deciLiter

dextrose 50% Injectable 25 Gram(s), IV Push, once, Stop After 1 DosesSpecial Instructions: Hypoglycemia Treatment. Conditional Order: Administer dextrose 50%, 25 Gram(s) IV Push STAT, for Patient blood glucose level LESS THAN 100 milliGRAM(s)/deciLiter. Notify Provider for blood glucose level LESS THAN 100 milliGRAM(s)/deciLiter

dextrose 50% Injectable 25 Gram(s), IV Push, once, Stop After 1 DosesSpecial Instructions: Hypoglycemia Treatment. Conditional Order: Administer dextrose 50%, 25 Gram(s) IV Push STAT, for Patient blood glucose level LESS THAN 50 milliGRAM(s)/deciLiter

dextrose Oral Gel 15 Gram(s), Oral, once, PRN for Blood Glucose LESS THAN 70 milliGRAM(s)/deciliter, Stop After 1 DosesSpecial Instructions: Hypoglycemia Treatment. Conditional Order: Administer one tube (15 grams) oral glucose gel and recheck blood glucose level in 15 to 30 minutes. 1. IF blood glucose level LESS THAN 70 milliGRAM(s)/deciLiter, REPEAT TREATMENT, and recheck blood glucose level in 15 to 30 minutes AND NOTIFY PROVIDER 2. IF blood glucose level 70-99 milliGRAM(s)/deciLiter, REPEAT TREATMENT, and recheck blood glucose level in 15 to 30 minutes AND NOTIFY PROVIDER 3. IF blood glucose level GREATER THAN OR EQUAL TO 100 milliGRAM(s)/deciLiter, and next meal is more than 1 hour away, give a light snack (1 carbohydrate and 1 protein; i.e. 1/2 cheese sandwich or cheese and crackers)

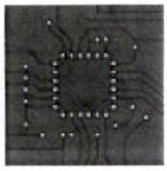
glucagon Injectable 1 milliGRAM(s), IntraMuscular, once, Stop After 1 DosesSpecial Instructions: Hypoglycemia Treatment. Conditional Order: Administer glucagon 1 mg Intramuscular for Patient BLOOD GLUCOSE LEVEL LESS THAN 70 milliGRAM(s)/deciLiter and no IV access

insulin lispro (ADMELOG) corrective regimen sliding scale 2 Unit(s) if Glucose 151 - 200 4 Unit(s) if Glucose 201 - 250 6 Unit(s) if Glucose 251 - 300 8 Unit(s) if Glucose 301 - 350 10 Unit(s) if Glucose 351 - 400 12 Unit(s) if Glucose Greater Than 400 + Contact MDSubCutaneous, three times a day before mealsSpecial Instructions: Give correctional scale insulin REGARDLESS of PO status NOTIFY Provider for blood glucose LESS THAN 70 milliGRAM(s)/deciLiter or GREATER THAN 400 milliGRAM(s)/deciLiterAdministration Instructions: *Per Sliding Scale*Dispose unused medication in BLACK bin.This is a High Alert Medication.

levothyroxine [Known as SYNTHROID]50 MICROGram(s), Oral, dailySpecial Instructions: Administer on an empty stomach at least 1 hour before food and other medicationsProvider's Contact #: (718) 226-3401

losartan [Known as COZAAR]50 milliGRAM(s), Oral, dailyProvider's Contact #: (718) 226-3401

regadenoson Injectable [Known as LEXISCAN]0.4 milliGRAM(s), IV Push, once, Stop After 1 DosesSpecial Instructions: To be administered by Stress LabProvider's Contact #: (718) 226-3401



RépondreTransférer

Name: ABDELILAH EL AMRANI JOUTEY
Date of Birth: 01-Dec-1953
Gender Identity: Male

Documents

5/5/2023Colleen M Kane, PA - ED CDU Provider Initial Day Note

OBSERVATION MONITORING PLAN DAY 1:

Observation Monitoring Plan:

- **Observation Order Date/Time::** 05-May-2023 16:41
- **Observation Monitoring Plan:** ED Record Reviewed
- **Indication for Observation:** Diagnostic Uncertainty
- **Assessment Plan:** Stress Test

HISTORY OF PRESENT ILLNESS:

Preferred Language to Address Healthcare:

- **Preferred Language to Address Healthcare** French

HPI:

- **Chief Complaint:** The patient is a 70y Male complaining of chest pain.
- **HPI Objective Statement:** 70 year old male, past medical history cad w/ stent, htn, hld, dm, hypothyroidism, who presents with chest pain. patient with intermittent episodes of L sided chest pain described as pressure with associated shortness of breath and dizziness described as room spinning. sx worse with exertion. denies f/c, hemoptysis, abd pain, back pain, n/v/d, leg pain/swelling. non-smoker. patient with stent placed x6 months in morraco.

PAST MEDICAL/SURGICAL/FAMILY/SOCIAL HISTORY:

Past Medical, Past Surgical, and Family History:

PAST MEDICAL HISTORY:
CAD (coronary artery disease)
DM (diabetes mellitus)
High cholesterol
HTN (hypertension)
Hypothyroid.

Tobacco Usage:

- **Tobacco Usage** Never smoker

ALLERGIES AND HOME MEDICATIONS:

Allergies:

Allergies:

No Known Allergies:

Home Medications:

**** Outpatient Medication Status not yet specified***

REVIEW OF SYSTEM:
Review of Systems:

- **Review of Systems:** Review of Systems

Constitutional: (-) fever, (-) chills

Eyes/ENT: (-) blurry vision, (-) epistaxis, (-) sore throat

Cardiovascular: (+) chest pain, (-) syncope

Respiratory: (-) cough, (+) shortness of breath

Gastrointestinal: (-) pain, (-) nausea, (-) vomiting, (-) diarrhea

Musculoskeletal: (-) neck pain, (-) back pain, (-) body aches

Integumentary: (-) rash, (-) edema

Neurological: (-) headache, (-) altered mental status

Psychiatric: (-) hallucinations

Allergic/Immunologic: (-) pruritus

VITAL SIGNS(Pullset):
Vital Signs:
,,ED ADULT Flow Sheet:

05-May-2023 11:06

- **Temp (F):** 98.1
- **Temp (C) Temp (C):** 36.7
- **Heart Rate Heart Rate (beats/min):** 75
- **BP Systolic Systolic:** 144
- **BP Diastolic Diastolic (mm Hg):** 65
- **Respiration Rate (breaths/min) Respiration Rate (breaths/min):** 20
- **SpO2 (%) SpO2 (%):** 98
- **O2 Delivery/Oxygen Delivery Method Patient On (Oxygen Delivery Method):** room air
- **Dosing Weight (KILOGRAMS) Dosing Weight (KILOGRAMS):** 74
- **Dosing Weight (POUNDS) Dosing Weight (POUNDS):** 163.1
- **SpO2 (%) SpO2 (%):** 98
- **Preferred Language to Address Healthcare Preferred Language to Address Healthcare:** French

PHYSICAL EXAM:
Physical Exam:

- **Physical Examination:** Gen: Alert, NAD, well appearing

Head: NC, AT, PERRL, EOMI, normal lids/conjunctiva

ENT: normal hearing

Neck: +supple, no tenderness/meningismus,

Pulm: Bilateral BS, normal resp effort, no wheeze/stridor/retractions

CV: RRR, + murmur

Abd: soft, NT/ND

Mskel: no edema/erythema/cyanosis

Skin: no rash, warm/dry

Neuro: AAOx3, no sensory/motor deficits

CURRENT ORDERS/ORDER ENTRY:
Orders:

- **Cardiac Monitor Bedside, Time/Priority: STAT**, 05-May-2023, Active, Standard
- **IV Insert, Time/Priority: STAT**, 05-May-2023, Active, Standard
- **Place in Observation, Service: OBS**

Physician: Kong

Diagnosis: Chest pain, 05-May-2023, Active, Standard

RESULTS:
Wet Read:
There are no Wet Read(s) to document.
(1) Order Name: Xray Chest 1 View- PORTABLE-Urgent Order ID: 0027GTD7P
Order Date/Time: 05-May-2023 12:44 Order Status: Resulted.
MDM DAY 1:
Medical Decision Making:

• **Justification:**	Patient with one or more new problems requiring additional work-up/treatment.
• **The following orders were submitted:**	Labs, EKG, Imaging Studies, Medications
• **EKG - Performed independent interpretation (See EKG Result section above)**	Yes
• **Clinical Summary (MDM): Summarize the clinical encounter**	

70 y/o M pmh as noted, placed in OBS for CP. ED w/up neg. Pt is comfortable. Plan for serial lab, ekg, nuc stress.

ATTESTATION STATEMENTS DAY 1:

Attestations Statements:

Attending Statement: This was a shared visit with the APP. I reviewed and verified the documentation and independently performed the documented:
History, Exam and Medical Decision Making.
Attending Contribution to Care: see mdm.

PROVIDER CARE INITIATION:

Provider Care:

- **Care Initiated by:** Kane, Colleen M(PA)
- **Provider Care Initiated at:** 05-May-2023 12:24

Electronic Signatures:

Chow, Mei K (PA) (Signed 05-May-2023 17:46)

Authored: *PAST MEDICAL/SURGICAL/FAMILY/SOCIAL HISTORY, REVIEW OF SYSTEM, VITAL SIGNS(Pullset), PHYSICAL EXAM*

Kane, Colleen M (PA) (Signed 05-May-2023 16:43)

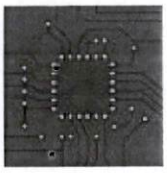
Authored: *OBSERVATION MONITORING PLAN DAY 1, HISTORY OF PRESENT ILLNESS, PAST MEDICAL/SURGICAL/FAMILY/SOCIAL HISTORY, ALLERGIES AND HOME MEDICATIONS, PHYSICAL EXAM, CURRENT ORDERS/ORDER ENTRY, RESULTS, PROVIDER CARE INITIATION*

Kong, Rodrigo I (MD) (Signed 08-May-2023 20:32)

Authored: *MDM DAY 1, ATTESTATION STATEMENTS DAY 1*

Co-Signer: *OBSERVATION MONITORING PLAN DAY 1, HISTORY OF PRESENT ILLNESS, PAST MEDICAL/SURGICAL/FAMILY/SOCIAL HISTORY, ALLERGIES AND HOME MEDICATIONS, REVIEW OF SYSTEM, VITAL SIGNS(Pullset), PHYSICAL EXAM, CURRENT ORDERS/ORDER ENTRY, RESULTS, PROVIDER CARE INITIATION*

Last Updated: *08-May-2023 20:32 by Kong, Rodrigo I (MD)*



RépondreTransférer