Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions					
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center				
Matricule: Primary			Date and Time:				
Nom:			Agreed healthcare	e networ	·k:		
Carte ID:							
Age:			Prescribing Docto	r / orien	tation:		
Marital Status :							
Gender :							
4. Details Of Medical Procedures:							
K OOE	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender :	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Prescribing Docto Marital Status: Gender: Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Designation (Medical Coefficient Rate		

<u>Important:</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			. Infos Referen enter	ce Medica	al .	
<u>Importar</u>	nt: The v	/alidit	y of this form cannot e	exceed 5 days	from the		Tota	ıl amount:	
date of is	sue						To be paid by t	he patient	
Assignment code						To be paid by the insurance company			
				5. Det	ails Of Pa	ram	edical Procedu	ıres:	
Date	nte Code Designation (Medical a		acts)	Coefficient		Rate Total Cost		:	
<u>lmportar</u>	<u>ıt:</u> The v	/alidit	y of this form cannot e	exceed 5 days			Total amount:		
from the	date of	issue			To be	paid	by the patient		
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp			Signature and stamp of the Doctor			the			
Prescribed (Section Reserved For Doctor)			The	Section Reserv ribing		erved			
No: Drugs		Dosage	age Quantity Total Cost						
			Total am	l amount:					
Important: The prescribing practitioner will			To be paid by the patient (%)						

Paeb crib Doctor)	indicate the duration of treatment for ed (Section Reserved For drug,	6. Medicines The Prescribing	Section Reserved For The Pharmacist	
and	variately carried exceeds 7 = 110 at 5 at cer	To be paid by MAADO		
Sigr	nature and stamp Prescribing Doctor	Signature and stamp Pharmacist		