# Medical Care Form

Claim number :

| 1. Health Insurance System Information | Filling Instructions |
|---|---|
| SAM code: | Write legibly |
| SAM: | ID obligatoire |

| Information & Access To Health Care | | 2. Patient<br>Policy | 3. Infos Reference Medical Center |
|---|---|---|---|
| Primary insured | Matricule: | | Date and Time: |
| | Nom: | prashant 1 2024-02-04 | Agreed healthcare network: |
| Patient | Carte ID: | | |
| | Full Name (first, middle, last): | prashant 1 2024-02-04 | |
| | Age: | 0.0 | Prescribing Doctor / orientation: Otis MillBurn |
| | Marital Status : | | |
| | Gender : | Male | |

**4. Details Of Medical Procedures:**

| Date | Code | Designation (Medical acts) | Coefficient | Rate | Total Cost |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

| Important: 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 | 3. Infos Reference Medical Center |
|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

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|---|---|---|
| Important: 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 | |

**5. Details Of Paramedical Procedures:**

| Date | Code | Designation (Medical acts) | Coefficient | Rate | Total Cost |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

| | | |
|---|---|---|
| Important: 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 | |

| Patient signature | Signature and stamp medical Healthcare centre | Signature and stamp of the Doctor |
|---|---|---|

| Prescribed (Section Reserved For Doctor) | 6. Medicines The Prescribing | Section Reserved For The Pharmacist |
|---|---|---|

| No: | Drugs | Dosage | Quantity | Total Cost |
|---|---|---|---|---|
| 1 | | | | 600 |

| | | |
|---|---|---|
| Important: The prescribing | Total amount: | 600.00 |

| | | |
|---|---|---|
| practitioner will<br>**Prescribed (Section Reserved For**<br>indicate the duration of treatment for each<br>**Doctor)**<br>drug, | **6. Medicines**<br><br>**The Prescribing** | **Section Reserved For The Pharmacist** |
| this form is valid only for one pharmacy and | To be paid by the patient (%) | 600.00 |
| its<br><br>validity cannot exceed 72 hours after<br><br>delivery | To be paid by MAADO | 0.00 |
| Signature and stamp Prescribing Doctor |  <br>Signature and stamp Pharmacist | |