## Medical Care Form Claim number:

4234

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:			Date and Time:			
Nom:	Dhanashree 23423 2023- 05-09		Agreed healthcare network:			
Carte ID:	234234					
Full Name (first, middle, last):	Dhanash	nree 23423 2023- 05-09				
Age:			Prescribing Doctor / orientation: 44 33 33			
Marital Status :						
Gender :	Female					
4. Details Of Medical Procedures:						
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost	
	Information  SAM code:  SAM:  Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  Iedical Procedures:	Information  SAM code:  SAM:  Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  Iedical Procedures:	Information  SAM code:  Write legibly  SAM:  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Dhanashree 23423 2023- 05-09  Carte ID:  234234  Full Name (first, middle, last):  Age:  0.3  Marital Status:  Gender:  Female  Iedical Procedures:  Code  Designation (Medical	Information  SAM code:  Write legibly  SAM:  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhanashree 23423 2023- 05-09  Carte ID:  234234  Full Name (first, middle, last):  Age:  O.3  Prescribing Doctorientation: 44 3:  Marital Status:  Gender:  Female  Iedical Procedures:  Code  Designation (Medical  Coefficient	Information  SAM code:  Write legibly  SAM:  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhanashree 23423 2023- 05-09  Carte ID:  234234  Full Name (first, middle, last):  Age:  O.3  Prescribing Doctor / orientation: 44 33 33  Marital Status:  Gender:  Female  Designation (Medical Coefficient Rate	

<u>Important:</u> The validity of this form ca	Total amount:		
the date of issu	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 Refere Center	nce Medio	cal	
Important: The validity of this form ca				nnot exceed 5 days from			m	Total amount:		
the date of issue					_			To be paid by the patient		
Assignment code				To be paid by th insurance compar			-			
5. Details Of Paramedical Procedures:								:		
Date	C	ode	Designation (Medical acts)		Coeffic	ient	Rate	Total Cost	t	
<u>lmportant:</u> The validity of this form canno					exceed 5		Total amount:			
days from the date of issue					To be p	paid by the patient				
Assignment code				To be paid by the insurance company						
I Patient signature I				Signature an Doctor	d stamp o	f the				
6.  Medicines Prescribed (Section Reserved For  The  Reserved For The Pharmacis  Prescribing Doctor)										
No	No: Drugs Dosage Quantity Total Cost									
•				•	Total amount: null					
<u>Important:</u> The prescribing practitioner will			oing	-	o be paid by ne patient (%)					

indicate the duration of  Medicines Presatibed (Section Reserved For  drug,  Prescribing Doctor)  this form is valid only for one	The	Section Reserved For The Pharmacist
pharmacy and its validity cannot exceed 72 hours after delivery	To be paid by MAADO	null
Signature and stamp Prescribing Doctor	Signatu	are and stamp Pharmacist