## **Medical Care Form**

Claim number :wefwefwef

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Access To Health Care			3. Infos Reference	Medical	Center	
Matricule:			Date and Time:			
Nom:	Lindsay Laura 1973-02- 12		Agreed healthcare network:			
Carte ID:	569161					
Full Name (first, middle, last):	Lindsay Laura 1973-02- 12					
Age:	50.7		Prescribing Doctor / orientation: wefwef wefwef wef			
Marital Status :						
Gender :	Female					
ledical Procedures:						
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost	
	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  edical Procedures:	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, lindsay last):  Age:  Age:  Gender:  Gender:  Female  Code  Designate	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Age:  50.7  Marital Status:  Gender:  Female  dedical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Lindsay Laura 1973-02-12  Agreed healthcare  Carte ID:  569161  Full Name (first, middle, Lindsay Laura 1973-02-12  Age:  Age:  Age:  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Lindsay Laura 1973-02-12  Agreed healthcare network  Carte ID:  Full Name (first, middle, Lindsay Laura 1973-02-12  Age:  Age:  So.7  Prescribing Doctor / orienta wefwef wefwef wef  Marital Status:  Gender:  Female  Designation (Medical Coefficient Rate	

<u>lmportant:</u> The validity of this form cannot	Total amount:		
date of issue		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Informat	formation & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center		
<u>Importan</u>	<u>t:</u> The validit	ty of this form cannot	exceed 5 days	from the		Tota	l amount:	
date of issue					To be paid by the patient			
Assignment code					To be paid by the insurance company			
			5. Det	ails Of Pa	ırame	edical Procedu	ıres:	
Date	Code Designation (Medical acts)		l acts)	Coefficie	pefficient Rate Tota		Total Cost	
_	Important: The validity of this form cannot exceed					Total amount:		
from the	date of issue	9		To be	paid	by the patient		
Assignme	nt code			To be pa	id by	the insurance company		
Patient	signature	re Signature and stamp medical Healthca			Signature and stamp of the Doctor			
Prescribed (Section Reserved For The			dicines ribing	Section Reserved				
No:	Dr	ugs	Dosage	Quantity	otal	Cost		
1				3	3			
	•		Total am	ount: 3	3.00			
<u>l</u> 1	<u>mportant:</u> T	he prescribing		1				

Prescrik each Doctor)	practitioner will ped (Section Reserved For indicate the duration of treatment for drug,	6. Medicines The Prescribing	Section Reserved For The Pharmacist
and	this form is valid only for one pharmacy	To be paid by the patient (%)	32.34
		To be paid by MAADO	0.66
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist