## **Medical Care Form**

Claim number: 34f3443

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
SAM:			ID obligatoire					
Access To Health Care	2. Patient Policy		3. Infos Reference Medical Center					
Matricule: rimary			Date and Time:					
Nom:	Suyesh	15151 2023-09-02	Agreed healthcare network:					
Carte ID:	22							
Full Name (first, middle, last):	Suyesh	15151 2023-09-02						
Age:	0.3		Prescribing Doctor / orientation: Otis MillBurn					
Marital Status :								
Gender :	Male							
edical Procedures:								
Loge			Coefficient	IRate	Total Cost			
	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  Edical Procedures:	Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  O.3  Marital Status:  Gender:  Male  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Suyesh 15151 2023-09-02  Carte ID: 22  Full Name (first, middle, last): Age: 0.3  Marital Status:  Gender: Male  dical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Suyesh 15151 2023-09-02 Agreed healthcare  Carte ID:  Full Name (first, middle, last):  Age:  O.3  Prescribing Docto Otis MillBurn  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Suyesh 15151 2023-09-02 Agreed healthcare networ  Carte ID:  22  Full Name (first, middle, last):  Age:  0.3  Prescribing Doctor / orient Otis MillBurn  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate			

<u>lmportant:</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 Medical			
Important: The validity of this form cannot excee			exceed 5 da	ys 1	from the		Tota	al amount:		
date of issue								To be paid by the patient		
Assignment code							To be paid by the insurance company			
	5. Details Of Paramedical Procedures:						ıres:			
Date	Date Code Designation (Medical acts)		acts)		Coefficient		Rate	Total Cost		
<u>Important:</u> The validity of this form cannot exceed			exceed 5 da	ys			Total amount:			
from the date of issue					To be	e paid	l by the patient			
Assignment code					To be paid by the insurance company					
Patient signature Signature and stamp medical He			eal	Signature and stamp of the Doctor						
Prescribed (Section Reserved For T			The	:	dicines  Section Reserved  For The Pharmacist					
No:		Drugs	rugs Dosage		ge C	Quantity	Total	tal Cost		
1							360			
<u>lr</u>	Important: The prescribing		Total	am	ount:	360.0	0			

Prescrib 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 (%)	237.60
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	122.40
Sig	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist