Medical Care Form

Claim number:3r3r3r

SAM: ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: Age: Gender: 4. Details Of Medical Procedures: Patient Policy 3. Infos Reference Medical Center Agreed healthcare network: Prescribing Doctor / orientation: 3r 3r 3r Prescribing Doctor / orientation: 3r 3r 3r Age: Age: Age: Age: Age: Age: Age: Age	1. Health Insurance System Information			Filling Instructions				
Information & Access To Health Care Policy Agreed healthcare network: Carte ID: Full Name (first, middle, last): Age: Age: Marital Status: Gender: A Details Of Medical Procedures: Pate Code Policy Agreed healthcare network: Prescribing Doctor / orientation: 3r 3r 3r Total	SAM code:			Write legibly				
Information & Access To Health Care Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: Marital Status: Gender: Designation (Medical Coefficient Rate Total	SAM:			ID obligatoire				
Primary insured Nom: Agreed healthcare network: Carte ID: Full Name (first, middle, last): Age: Prescribing Doctor / orientation: 3r 3r 3r Marital Status: Gender: 4. Details Of Medical Procedures: Date Code Designation (Medical Coefficient Rate Total	Information &	Access To Health Care		2. Patient		e Medica	al	
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Patient Age: Age: Age: Marital Status: Gender: 4. Details Of Medical Procedures: Date Code Prescribing Doctor / orientation: 3r 3r 3r Prescribing Doctor / orientation: 3r 3r 3r Age: Prescribing Doctor / orientation: 3r 3r 3r Prescribing Doctor / orientation: 3r 3r 3r Age: Designation (Medical Coefficient Rate Total	insured	Nom:			Agreed healthcare	e networ	·k:	
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4. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total		Marital Status :						
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	Date	Code	Designa acts)	ation (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		3. Infos Reference Medical Center		
Important: The validity of this form cannot excee			exceed 5 days	from the		Tota	al amount:	
date of is	ssue			-	To be paid by the patient			
Assignm	ent code			To be paid by the insurance company				
			5. Det	ails Of Pa	aram	edical Procedu	ıres:	
Date	Code	Designation (Medical a	acts)	Coefficie	ent	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot excee		exceed 5 days	i 5 days		Total amount:			
from the date of issue				To be	paid	by the patient		
Assignment code				To be pa	aid by the insurance company			
Patient signature Signature and stamp medic			medical Heal	thcare ce	entre	Signature and Doctor	l stamp of the	
Prescribo	ed (Section R	eserved For	6. Med The Presci	dicines ribing	For Tl	Se he Pharmacist	ction Reserved	
No:	Drugs		Dosage	Quantity	Total	Cost		
1 afrom excel 1qq		1 1	l	1				
	•		Total am	ount:	1.00			
<u>Important:</u> The prescribing								

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 (%)	0.98
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.02
Signature and stamp Prescribing Doctor		Signat	ture and stamp Pharmacist