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 Center Policy		e Medica	al	
Matricule:			Date and Time:			
Nom:	Prashant 2000-10-10		Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Prashant 2000-10-10					
Age:	23.3		Prescribing Doctor / orientation: Otis MillBurn			
Marital Status :						
Gender :	Male					
4. Details Of Medical 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: Prashar Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2000-10-10 Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2000-10-10 Agreed healthcare Full Name (first, middle, last): Age: Age: 23.3 Prescribing Docto Otis MillBurn Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2000-10-10 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Age: 23.3 Prescribing Doctor / orien 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		Reference Medica	al		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Total amount:		
date of issue					To be pa	To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	ramedical P	rocedures:		
Date	Code	Designation (Medical acts)		Coefficier	nt Rate	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed 5 from the date of issue			exceed 5 days		Total a	mount:		
				To be paid by the patient				
Assignment code				To be pai	e paid by the insurance company			
Patient signature Signature and stamp medical Heal			Signature and stamp of the Doctor			the		
Prescribed (Section Reserved For The			dicines ribing	Section Reserved For The Pharmacist				
No:	Dr	ugs	Dosage	QuantityT	otal Cost			
1		P11111111		0				
			Total am	ount: 3	00			
Important: The prescribing			-					

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 (%)	60
		To be paid by MAADO	240
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist	