Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions					
SAM code:		Write legibly					
SAM:			ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center		al		
Matricule:			Date and Time:				
Nom:	Dhiraj G. 2000-06-18		Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Dhiraj G. 2000-06-18						
Age:	23.4		Prescribing Doctor / orientation:				
Marital Status :							
Gender :	Male						
edical Procedures:							
l one	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, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Code Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare netword Carte ID: Full Name (first, middle, last): Age: 2. Patient Policy Date and Time: Agreed healthcare netword Agreed healthcare netword Prescribing Doctor / orient Marital Status: Gender: Male Designation (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 Policy		nfos Referen nter	ce Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	il amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
	5. Details Of Paramedical Procedures:					res:		
Date	Code	Designation (Medical acts)		Coefficie	nt l	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed 5			exceed 5 days		Т	otal amount:		
from the o	date of issue			To be	paid b	y the patient		
Assignment code				To be pa	oe paid by the insurance company			
Patient signature Signature and stamp medical Heal			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The				dicines ribing	Section Reserved For The Pharmacist			
No:	Dr	ugs	Dosage(QuantityT	otal C	ost		
1				4	884			
			Total am	ount: 4	884.00	0		
Important: The prescribing								

Prescrib each Doctor)	practitioner will 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 (%)	0.00
		To be paid by MAADO	4884.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist