Medical Care Form

Claim number:qaqa

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
		ID obligatoire				
Access To Health Care			3. Infos Reference Center	e Medica	al	
Matricule: Primary insured Nom:			Date and Time:			
			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto qa qa qa	r / orien	tation:	
Marital Status :						
Gender :						
4. Details Of Medical 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 :	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Age: Marital Status: Gender: Designation (Medical Coefficient Rate	

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		To be paid by the patient	
Assignment code		To be paid by the insurance company	

nformation & Access To Health Care		2. Patient Policy		3. Infos Reference Medical Center		
nportant: The validity of this form cannot e	xceed 5 days t	from the		Tota	ıl amount:	
ate of issue			T	o be paid by t	he patient	
ssignment code		To be paid by insurance comp				
	5. Det	ails Of Par	ame	edical Procedu	ıres:	
ate Code Designation (Medical a	Code Designation (Medical acts)		Coefficient R		Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5 c				Total amount:		
om the date of issue		To be p	aid	by the patient		
ssignment code		To be paid	d by	the insurance company		
Patient signature Signature and stamp	gnature - I Signature and Stamp medical Healthcare centre-I			Signature and stamp of the Doctor		
rescribed (Section Reserved For octor)	6. Med The Prescr	dicines ribing	or Th	Seo ne Pharmacist	ction Reserved	
o: Drugs	Dosage	QuantityTo	otal (Cost		
ggx	2 2	2 4				
<u>Important:</u> The prescribing	Total am	ount: 4.	00			

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 (%)	2.64
		To be paid by MAADO	1.36
Sigr	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist