Medical Care Form

Claim number:sdfw3e

1. Health Insurance System Information		Filling Instructions				
SAM code:			Write legibly			
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:	Prashant 1998-10-28		Agreed healthcare network:			
Carte ID:	123					
Full Name (first, middle, last):	Prashant 1998-10-28					
Age:	25.2		Prescribing Doctor / orientation:			
Marital Status :						
Gender :	Male					
4. Details Of Medical Procedures:						
COGE	Designation (Medical acts)		Coefficient	IRate	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: 123 Full Name (first, middle, last): Age: 25.2 Marital Status: Gender: Male Access To Health Care Marital Status Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1998-10-28 Carte ID: 123 Full Name (first, middle, last): Age: 25.2 Marital Status: Gender: Male dical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1998-10-28 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: 25.2 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 1998-10-28 Agreed healthcare networ Carte ID: 123 Full Name (first, middle, last): Age: 25.2 Prescribing Doctor / orient Marital Status: Gender: Male Pasignation (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		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 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. Det	ails Of Pa	ırame	edical Procedu	ıres:	
Date	Code	Code Designation (Medical acts)		Coefficie	nt	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot excee			exceed 5 days	days		Total amount:		
from the o	date of issue			To be	paid	by 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			6. Med The Prescr	dicines	Section Reserved For The Pharmacist			
No:	Dr	ugs	Dosage	Quantity 1	otal (Cost		
1				1	10			
	•		Total am	ount: 1	0.00			
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 (%)	2.00
		To be paid by MAADO	8.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist