Medical Care Form

Claim number:

h Insurance System Informa	Filling Instructions						
SAM code:			Write legibly				
		ID obligatoire					
Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:	sourabl	า 2000-11-23	Agreed healthcare network:				
Carte ID:	123						
Full Name (first, middle, last):	sourabl	า 2000-11-23					
Age:	23.2		Prescribing Doctor / orientation: wef wef wef				
Marital Status :							
Gender :	Male						
edical Procedures:							
LOGE	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:	Matricule: Nom: sourable Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Marital Status: Gender: Male Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: sourabh 2000-11-23 Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Marital Status: Gender: Male edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Sourabh 2000-11-23 Full Name (first, middle, last): Age: Age: 23.2 Prescribing Doctowef wef wef Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Sourabh 2000-11-23 Full Name (first, middle, last): Age: Age: 23.2 Prescribing Doctor / orient wef wef wef 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			3. Infos Refe	renc	e Medical		
Important: The validity of this form cannot exceed					xceed	d 5 days	from the		Т	otal	amount:
date of issue								To be paid by the patient			
Assignment code						To be paid by the insurance company					
						5. Det	ails Of P	aran	nedical Proc	edur	es:
Date	ate Code Designation (Medical acts)			Coefficient		Rate	Т	otal Cost			
<u>Important:</u> The validity of this form cannot exceed			xceed	d 5 days			Total amou	ınt:			
from the date of issue				To be p			d by the pati	ent			
Assignment code						To be paid by the insurance company					
Patient signature Signature and stamp medical Healthcare centre Doctor						stamp of the					
Prescribed (Section Reserved For The						dicines	Section Reserved For The Pharmacist				
No:	Drugs	5				Dosage (Quantity	Tota	l Cost		
1	gabap	pentine	ranb	axy 400 mg, gélule		10	10	100			
						Total an	nount:	100.0	00		
Important: The prescribing			ŀ	<u> </u>							

Prescrik each Doctor)	practitioner will bed (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 (%)	40.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	60.00
Sig	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist