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 Policy | Center | | ıl | |
| Primary | Matricule: | | | Date and Time: | | | |
| insured | Nom: | prashant 1 2024-02-04 | | Agreed healthcare network: | | | |
| | Carte ID: | | | | | | |
| | Full Name (first, middle, last): | prashant 1 2024-02-04 | | | | | |
| Patient | Age: | 0.0 | | Prescribing Doctor / orientation: Dr Anchal | | | |
| | Marital Status : | | | | | | |
| | Gender : | Male | | | | | |
| 4. Details Of M | edical Procedures: | | | | | | |
| Date | l one | Designation (Medical acts) | | Coefficient | Rate | Total Cost | |
| | | | | | | | |
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| | | · | | | | | |

| <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 | |

| Doctor) The Prescribing For The Pharmacist Dosage Quantity Total Cost Total amount: 200.00 | Information & Access To Health Care | | | | 2. Patient Policy | | 3. Infos Reference Medical Center | | |
|--|--|-----------------------|-------------------------|----------------|----------------------|------|--------------------------------------|----------------|--|
| Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the insurance company 5. Details Of Paramedical Procedures: Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the patient To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Prescribed (Section Reserved For The Pharmacist To Dosage Quantity Total Cost Total amount: 200 Total amount: 200.00 | | | | | | | | | |
| Assignment code To be paid by the insurance company 5. Details Of Paramedical Procedures: Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Prescribed (Section Reserved For The Pharmacist The Prescribing For The Pharmacist Total amount: 200.00 | <u>Important</u> | <u>t:</u> The validit | y of this form cannot e | exceed 5 days | from the | | Tota | al amount: | |
| S. Details Of Paramedical Procedures: Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient Assignment code Patient signature Signature and stamp medical Healthcare centre Company Frescribed (Section Reserved For The Pharmacist For The Pharmacist Total amount: To be paid by the insurance company Signature and stamp of the Doctor Doctor Doctor Dosage Quantity Total Cost 1 200 Total amount: | date of iss | sue | | | | | To be paid by the patient | | |
| Date Code Designation (Medical acts) Coefficient Rate Total Cost Important; The validity of this form cannot exceed 5 days from the date of issue Assignment code To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Doctor Frescribed (Section Reserved For The Pharmacist Total Cost 200 Doctor) Doctor Total amount: 200.00 | Assignme | nt code | | | | | | | |
| Important: The validity of this form cannot exceed 5 days from the date of issue Assignment code Patient signature Signature and stamp medical Healthcare centre Signature and stamp of the Doctor Company Assignment code Prescribed (Section Reserved For The Pharmacist Doctor) Dosage Quantity Total Cost To be paid by the patient Signature and stamp of the Doctor Section Reserved For The Pharmacist To be paid by the patient To be paid by the insurance company Signature and stamp of the Doctor Total amount: 200.00 | | | | 5. Det | ails Of Pa | ramo | edical Procedu | ıres: | |
| Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Octor 6. Medicines The Prescribing Prescribing Doctor Doctor Doctor Doctor Doctor Doctor Doctor To be paid by the insurance company Signature and stamp of the Doctor For The Pharmacist Section Reserved For The Pharmacist 1 200 Total amount: 200.00 | Date | Code | Designation (Medical a | acts) | Coefficient Rate | | Rate | Total Cost | |
| Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Octor 6. Medicines The Prescribing Prescribing Doctor Doctor Doctor Doctor Doctor Doctor Doctor To be paid by the insurance company Signature and stamp of the Doctor For The Pharmacist Section Reserved For The Pharmacist 1 200 Total amount: 200.00 | | | | | | | | | |
| Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Octor 6. Medicines The Prescribing Prescribing Doctor Doctor Doctor Doctor Doctor Doctor Doctor To be paid by the insurance company Signature and stamp of the Doctor For The Pharmacist Section Reserved For The Pharmacist 1 200 Total amount: 200.00 | | | | | | | | | |
| Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Octor 6. Medicines The Prescribing Prescribing Doctor Doctor Doctor Doctor Doctor Doctor Doctor To be paid by the insurance company Signature and stamp of the Doctor For The Pharmacist Section Reserved For The Pharmacist 1 200 Total amount: 200.00 | | | | | | | | | |
| Patient signature Signature and stamp medical Healthcare centre Signature and stamp of the Doctor Frescribed (Section Reserved For The Pharmacist Doctor) Dosage Quantity Total Cost Total amount: 200.00 | | | - | exceed 5 days | 5 days | | Total amount: | | |
| Patient signature Signature and stamp medical Healthcare centre Company Signature and stamp of the Doctor Company Signature and stamp of the Doctor Company Signature and stamp of the Doctor Frescribed (Section Reserved For The Pharmacist Doctor) Doctor Doctor | from the o | date of issue | | | To be | paid | by the patient | | |
| Prescribed (Section Reserved For The Prescribing Doctor Doctor Total amount: Doctor Section Reserved For The Pharmacist Section Reserved For The Pharmacist 200.00 | Assignme | nt code | | | I I | | | | |
| Prescribed (Section Reserved For The Prescribing For The Pharmacist No: Drugs Dosage Quantity Total Cost 1 200 Total amount: 200.00 | Patient signature Signature and stamp me | | | o medical Heal | thcare ce | ntre | | l stamp of the | |
| 1 200 Total amount: 200.00 | Prescribed (Section Reserved For Doctor) | | | The | Section Reserved | | | | |
| Total amount: 200.00 | No: | Dri | ugs | Dosage(| QuantityT | otal | Cost | | |
| | 1 | | | | 2 | 200 | | | |
| | Important: The prescribing | | | Total am | nount: 200.00 | | | | |

| Prescril 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 (%) | 200.00 | |
| | | To be paid by MAADO | 0.00 | |
| Signature and stamp Prescribing Doctor | | Signature and stamp Pharmacist | | |