Medical Care Form

Claim number:t5t5t

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:	tttttttt ffffff 2023-07-02		Agreed healthcare network:			
Carte ID:	43234					
Full Name (first, middle, last):	tttttttt ffffff 2023-07-02					
Age:	0.3		Prescribing Doctor / orientation: erg erg erg			
Marital Status :						
Gender :	Male					
edical Procedures:						
Lone	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: tttttttt f Carte ID: 43234 Full Name (first, middle, last): Age: 0.3 Marital Status : Gender : Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: tttttttt ffffff 2023-07-02 Carte ID: 43234 Full Name (first, middle, last): Age: 0.3 Marital Status : Gender : Male dical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: tttttttt ffffff 2023-07-02 Agreed healthcare Carte ID: 43234 Full Name (first, middle, last): Age: 0.3 Prescribing Doctoerg erg erg Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Center Matricule: Date and Time: Nom: Carte ID: 43234 Full Name (first, middle, last): Age: O.3 Prescribing Doctor / orienter erg erg erg 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. Pati Policy		3. Infos Referei Center	nce Medical	
<u>lmporta</u> ı	nt: The val	idity of this form cannot e	exceed 5 days	from the	Tot	al amount:
date of i	ssue				To be paid by	the patient
Assignment code				To be paid by the insurance company		
			5. Det	ails Of Pa	ramedical Proced	ures:
Date	Code	Designation (Medical acts)		Coefficie	nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5		exceed 5 days		Total amount	:	
from the	date of is	sue		To be	paid by the patien	t
Assignm	ent code			To be pa	id by the insurance company	
Patien	t signatur	re Signature and stamp medical Healthcare centre Doctor				
Prescribed (Section Reserved For The Prescribing Doctor) 6. Medicines Section Reserved For The Pharmacist						
No: Drug	gs		Dosage	Quantity ⁻	Total Cost	
-	prazole sa ispersible	indoz 10 mg, comprimé	33	33 [′]	1089	
	lua	h. The Marie 2011 11 11	Total an	nount: I	null	
	<u>ımportan</u> ı	<u>t:</u> 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	Alaia fa i a li al a li . fa a a la a a	To be paid by the patient (%)	null
		To be paid by MAADO	null
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist