## **Medical Care Form**

Claim number:1234

1. Health Insurance System Information		Filling Instructions					
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care		2. Patient	3. Infos Reference Medica Center		al		
Matricule:			Date and Time:				
Nom:		élatou 1959-05-	Agreed healthcare network:				
Carte ID:	500511						
		élatou 1959-05-					
Age:	64.4		Prescribing Doctor / orientation: 2w 2w 1w				
Marital Status :							
Gender :	Female						
edical Procedures:							
Code	Designation (Medical acts)		Coefficient	Rate	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: Carte ID: Full Name (first, middle, last): Age: Age: Gender: Female  Gender: Female	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Orlane Lélatou 1959-05-18  Carte ID:  Full Name (first, middle, last):  Age:  Age:  Gender:  Female  edical Procedures:	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Orlane Lélatou 1959-05-18  Carte ID:  Full Name (first, middle, last):  Age:  Age:  64.4  Prescribing Docto 2w 2w 1w  Marital Status :  Gender :  Female  edical Procedures:	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Orlane Lélatou 1959-05- 18  Carte ID:  Full Name (first, middle, last):  Age:  Age:  64.4  Prescribing Doctor / orient 2w 2w 1w  Marital Status:  Gender:  Female  edical Procedures:		

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

Informati	nformation & Access To Health Care			2. Patient Policy			. Infos Referen enter	ce Medical
Important: The validity of this form cannot exceed			exceed 5 c	days 1	from the		Tota	al amount:
date of issue				To be paid by the patient			he patient	
Assignment code					To be paid by the insurance company			
5. Details Of Paramedical Procedures:						ıres:		
Date	Date Code Designation (Medical acts)			Coefficient Rate		Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5			exceed 5 c	days			Total amount:	
from the c	date of issue				To be	e paid	by the patient	
Assignment code			To be p	e paid by the insurance company				
Patient	t signature Signature and stamp medical Healt			thcare co	centre Doctor			
Prescribed (Section Reserved For The			he	dicines	Section Reserved For The Pharmacist			
No:	Drugs		Dos	sage (	Quantity	Total	Cost	
1 ABJVCFU		011	00 1	100	1110	11100		
l <sub>w</sub>	mnortant: T	he prescribing	Tota	al am	ount:	1110	0.00	
<u>11</u>	<u>portant.</u> 1	ne preserioring	1					

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 (%)	10878.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	222.00
Sigı	nature and stamp Prescribing Doctor	Signat	<i>ெ</i> ture and stamp Pharmacist