Medical Care Form

Claim number:5345

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:		ID obligatoire				
Access To Health Care		2. Patient	3. Infos Reference Center	e Medica	al	
Matricule:			Date and Time:			
Nom:	prashant kumar 1998-10- 28		Agreed healthcare network:			
Carte ID:	574372					
Full Name (first, middle, last):	prashant kumar 1998-10- 28					
Age:			Prescribing Doctor / orientation: fd fd fd			
Marital Status :						
Gender :	Male					
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, prashandlast): Age: Age: Gender: Male Male edical Procedures:	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: 24.8 Marital Status: Gender: Male Mrite legibly ID obligatoire 2. Patient Policy Age: 24.8 Marital Status: Gender: Male	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: 24.8 Marital Status: Gender: Male Write legibly ID obligatoire 3. Infos Reference Center Agreed healthcare Agreed healthcare Prescribing Doctor dd fd fd Male	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant kumar 1998-10-28 Carte ID: Full Name (first, middle, last): Age: Age: Age: Age: Age: Age: Age: Age	

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Informati	2. Pat rmation & Access To Health Care Policy		ient		Infos Referen enter	ce Medical	
<u>Important</u>	<u>t:</u> The validit	y of this form cannot (exceed 5 days 1	from the		Tota	al amount:
date of iss	sue				7	Γo be paid by t	he patient
Assignment code					To be paid by the insurance company		
			5. Det	ails Of Pa	ıramı	edical Procedu	ıres:
Date	Code	Code Designation (Medical acts)		Coefficie	nt	Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5 d		exceed 5 days			Total amount:		
from the (date of issue	2		To be	paid	by the patient	
Assignment code			To be pa	e paid by the insurance company			
Patient	signature	Signature and stamp medical Healthcare centre Doctor			l stamp of the		
6. Me Prescribed (Section Reserved For The Presc Doctor)			dicines	or Th	Section Reserved or The Pharmacist		
No:	Dru	ugs	Dosage	QuantityT	otal	Cost	
Important: The prescribing practitioner will		Total am	Total amount: null				
			To be paid by the patient (%)		I		

indicate the duration of treatment for Paebcribed (Section Reserved For drug, Doctor)	The Prescribing	Section Reserved For The Pharmacist
and its validity cannot exceed 72 hours after	To be paid by	null
delivery Signature and stamp Prescribing Doctor		
Signature and Stamp Prescribing Doctor	Signa	ture and stamp Pharmacist