Medical Care Form

Claim number::6456

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:	Prashant 1997-10-28		Agreed healthcare network:			
Carte ID:	234					
Full Name (first, middle, last):	Prashant 1997-10-28					
Age:	1/5 X		Prescribing Doctor / orientation: 5345 345 345			
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:	Access To Health Care Matricule: Nom: Prashar Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status : Gender: Male edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status: Gender: Male dical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Agreed healthcare Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Prescribing Docto 5345 345 345 Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Center Matricule: Date and Time: Nom: Prashant 1997-10-28 Agreed healthcare networ Carte ID: 234 Full Name (first, middle, last): Age: Age: 25.8 Prescribing Doctor / orient 5345 345 345 Marital Status: Gender: Male Designation (Medical Coefficient Rate	

<u>Important:</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	

Informati	2. Pati ormation & Access To Health Care Policy			3. Infos Reference Medica Center		ce Medical		
lmportant	: The validit	y of this form cannot e	exceed 5 days f	from the		Tota	al amount:	
date of issue					To be paid by the patient			
Assignment code						To be paid by the insurance company		
			5. Det	ails Of Pa	iram	edical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coefficie	ent Rate		Total Cost	
Important: The validity of this form cannot exceed 5 da		exceed 5 days			Total amount:			
from the o	late of issue			To be	paid	by the patient		
Assignment code			To be pa	o be 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	Section Reserved or The Pharmacist				
No:	Dru	ugs	Dosage	Quantity	Γotal	Cost		
Important: The prescribing practitioner will		Total am	ount: null					
			To be paid by the patient (%)		I			

indicate the duration of treatment for Paebcribed (Section Reserved For drug, Doctor)	6. Medicines The Prescribing	Section Reserved For The Pharmacist	
this form is valid only for one pharmac and its validity cannot exceed 72 hours after delivery	To be paid by MAADO	null	
Signature and stamp Prescribing Doctor	Signature and stamp Pharmacist		