Medical Care Form

Claim number : 4234

1. Health Insurance System Information	Filling Instructions
SAM code:	Write legibly
SAM:	ID obligatoire

Information & Access To Health Care		2. Patient Policy	3. Infos Reference Medical Center
Primary insured	Matricule:		Date and Time:
	Nom:	Dhanashree 23423 2023-05-09	Agreed healthcare network:
Patient	Carte ID:	234234	
	Full Name (first, middle, last):	Dhanashree 23423 2023-05-09	
	Age:	0.3	Prescribing Doctor / orientation: 44 33 33
	Marital Status :		
	Gender :	Female	

4. Details Of Medical Procedures:

Date	Code	Designation (Medical acts)	Coefficient	Rate	Total Cost

<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	

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			**Total amount:**		
			To be paid by the patient		
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			**Total amount:**		
			To be paid by the patient		
Assignment code			**To be paid by the insurance company**		
Patient signature	**Signature and stamp medical Healthcare centre**		**Signature and stamp of the Doctor**		

Medicines Prescribed (Section Reserved For Prescribing Doctor)		**6. The**		**Section Reserved For The Pharmacist**
No:	**Drugs**	**Dosage**	**Quantity**	**Total Cost**
Important: The prescribing practitioner will		**Total amount:**		null
		To be paid by the patient (%)		null

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