Medical Care Form

Claim number :xxx

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:	Suyesh 15151 2023-09-02	Agreed healthcare network:
Patient	Carte ID:	22	
	Full Name (first, middle, last):	Suyesh 15151 2023-09-02	
	Age:	0.3	Prescribing Doctor / orientation:
	Marital Status :		
	Gender :	Male	

4. Details Of Medical 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	

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

Prescribed (Section Reserved For Doctor)	6. Medicines The Prescribing	Section Reserved For The Pharmacist

No:	Drugs	Dosage	Quantity	Total Cost
1				40

Important: The prescribing	Total amount:	40.00

practitioner will indicate the duration of treatment for each drug, **Prescribed (Section Reserved For Doctor)**	**6. Medicines The Prescribing**	**Section Reserved For The Pharmacist**
this form is valid only for one pharmacy and its validity cannot exceed 72 hours after delivery	To be paid by the patient (%)	26.40
	To be paid by MAADO	13.60
Signature and stamp Prescribing Doctor	 Signature and stamp Pharmacist	