Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
		ID obligatoire				
Access To Health Care			3. Infos Reference Center	e Medica	al	
Matricule:			Date and Time:			
Nom:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto fwef wef wef	r / orien	tation:	
Marital Status :						
Gender :						
4. Details Of Medical Procedures:						
l one	Designa acts)	ation (Medical	Coefficient	Rate	Total Cost	
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender:	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Designation (Medical Coefficient Rate	

<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	

<u>Important:</u> The validity of this form car	nnot excee	ed 5 days t	from the		Tota	al amount:	
date of issue					To be paid by t	he patient	
Assignment code		To be paid by the insurance company					
		5. Det	ails Of Pa	aram	edical Procedu	ıres:	
Date Code Designation (Me	de Designation (Medical acts)		Coefficie	pefficient Rate		Total Cost	
<u>Important:</u> The validity of this form cannot exceed					Total amount:		
from the date of issue			To be	paid	by the patient		
Assignment code			To be pa	aid by	the insurance company		
Patient signature Signature and stamp medical Healthcare centre Doctor				Signature and Doctor	l stamp of the		
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)				Seo he Pharmacist	ction Reserved		
No: Drugs		Dosage (Quantity	Total	Cost		
1 image		10 1	0	100			
<u>Important:</u> The prescribing		Total am	ount:	100.0	0		

Prescrik each Doctor)	practitioner will bed (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 (%)	20.00
		To be paid by MAADO	80.00
Sig	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist