Medical Care Form

Claim number:

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:				
rimary sured Nom: Dhira		5. 2000-06-18	Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Dhiraj (5. 2000-06-18					
Age:	23.4		Prescribing Doctor / orientation: fsd sdf sdf				
Marital Status :							
Gender :	Male						
4. Details Of Medical 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, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto fsd sdf sdf Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare netword Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Doctor / orient fsd sdf sdf 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	

nformation & /	formation & Access To Health Care			2. Patient Policy			3. Infos Reference Medical Center		
mportant: The	validity	y of this form cannot e	exceed 5	5 days 1	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 P	arame	edical Procedu	ıres:	
Date Code	ate Code Designation (Medical acts)				Coefficie	ent	Rate	Total Cost	
Important: The validity of this form cannot exceed 5			5 days			Total amount:			
rom the date o	f issue				To be	e paid	by the patient		
Assignment code			To be p	e paid by the insurance company					
Patient signat	ture	Signature and stamp medical Healthcare				entre	Signature and stamp of the Doctor		
Prescribed (Section Reserved For The			6. Med The Prescr	dicines	Section Reserved For The Pharmacist				
No: Drug	gs		Do	osage (Quantity	Total	Cost		
tomjerryhop		10) 1	0	100				
Important: The prescribing		To	otal am	ount:	100.00				

Prescrib each Doctor)	practitioner will ped (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
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	80.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist