


# Medical Care Form

Claim number :

| 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:                             |                            | Agreed healthcare network:        |      |                                   |
| Patient                                | Carte ID:                        |                            |                                   |      |                                   |
|                                        | Full Name (first, middle, last): |                            |                                   |      |                                   |
|                                        | Age:                             |                            | Prescribing Doctor / orientation: |      |                                   |
|                                        | Marital Status :                 |                            |                                   |      |                                   |
|                                        | Gender :                         |                            |                                   |      |                                   |
| 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   |  |
|                                                                                         |       |                                               |                                     |                                   |                                     |  |
| <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 |                                   |                                     |  |
| 5. Details Of Paramedical 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 |                                   |                                     |  |
| 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                        |                                     |  |
| <u>Important:</u> The prescribing practitioner will                                     |       | Total amount:                                 |                                     |                                   |                                     |  |
|                                                                                         |       | To be paid by the patient (%)                 |                                     |                                   |                                     |  |

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