## **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	3. Infos Reference Medical Center			
Matricule: mary			Date and Time:			
Nom:	Suyesh 15151 2023-09-02		Agreed healthcare network:			
Carte ID:	22					
Full Name (first, middle, last):	Suyesh 15151 2023-09-02					
Age:	0.3		Prescribing Doctor / orientation:			
Marital Status :						
Gender :	Male					
edical Procedures:						
Loge	Designation (Medical acts)		Coefficient	IRate	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:  22  Full Name (first, middle, last):  Age:  O.3  Marital Status:  Gender:  Male  Addical Procedures:  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Suyesh 15151 2023-09-02  Carte ID: 22  Full Name (first, middle, last): Age: 0.3  Marital Status:  Gender: Male  dical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Suyesh 15151 2023-09-02 Agreed healthcare  Carte ID:  Full Name (first, middle, last):  Age:  O.3  Prescribing Docto  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Center  Matricule:  Date and Time:  Nom:  Suyesh 15151 2023-09-02 Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  0.3  Prescribing Doctor / orient  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate	

<u>lmportant:</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	

Information & Access To Health Care			2. Patient Policy		nce Medical		
Important: The validity of this form cannot exceed			exceed 5 days	from the	Tot	al amount:	
date of issue					To be paid by	To be paid by the patient	
Assignmeı	Assignment code			To be paid by t insurance compa		-	
			5. Det	ails Of Paı	ramedical Proced	ures:	
Date	Date Code Designation (Medical acts)		acts)	Coefficien	nt Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days		Total amount	::	
from the o	date of iss	sue		To be p	oaid by the patien	t	
Assignment code				To be paid by the insurance company			
Patient signature Signature and stamp medical Healthcare			thcare cer	Signature an Doctor	d stamp of the		
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)  6. Medicines Section Reser				ection Reserved t			
No:		Drugs	Dosage(	QuantityTo	otal Cost		
1				40	0		
<u>lr</u>	<u>Important:</u> The prescribing		Total am	ount: 40	0.00		

Prescrik 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 (%)	26.40
		To be paid by MAADO	13.60
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist