Medical Care Form

Claim number:232

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:			
Nom:	dhiraj 2001-10-10		Agreed healthcare network:			
Carte ID:	32332					
Full Name (first, middle, last):	dhiraj 2001-10-10					
Age:	22.3		Prescribing Doctor / orientation: ree tretr rtr			
Marital Status :						
Gender :	Male					
edical Procedures:						
Lone	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: 32332 Full Name (first, middle, last): Age: 22.3 Marital Status: Gender: Male Addical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: dhiraj 2001-10-10 Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Marital Status: Gender: Male dical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: dhiraj 2001-10-10 Agreed healthcare Full Name (first, middle, last): Age: 22.3 Prescribing Doctore tret rtr Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: dhiraj 2001-10-10 Agreed healthcare networ Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Prescribing Doctor / orient ree tretr rtr 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		3. Infos Refere Center	ence Medical		
<u>Important</u>	<u>::</u> The validit	y of this form cannot e	exceed 5 day	s from th	ne	То	tal amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. De	tails Of	Para	medical Proced	dures:	
Date	ce Code Designation (Medical acts)		acts)	Coeffic	cient	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed			exceed 5 day	5		Total amoun	t:	
from the o	date of issue			То	be pa	id by the patier	nt	
Assignment code				To be	paid	paid by the insurance company		
Patient	signature	Signature and stamp medical Health			centr	entre Signature and stamp of the Doctor		
Prescribed Doctor)	d (Section R	eserved For	The	edicines cribing		S The Pharmaci	ection Reserved st	
No:	Drugs		Dosage	Quantit	ty Tot	al Cost		
1	taaaaaaaa	aa	o	0	0			
			Total a	mount:	0.00	0		
Important: The prescribing								

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 (%)	0.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist