Medical Care Form

Claim number: f44444

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:	sam Fna 1937-12-30		Agreed healthcare network:			
Carte ID:	549050					
Full Name (first, middle, last):	sam Fna 1937-12-30					
Age:	86.0		Prescribing Doctor / orientation: dhiraj gurve			
Marital Status :						
Gender :	Female					
4. Details Of Medical 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: Sam Fn. Carte ID: 549050 Full Name (first, middle, last): Age: Age: 86.0 Marital Status: Gender: Female edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: sam Fna 1937-12-30 Carte ID: 549050 Full Name (first, middle, last): Age: 86.0 Marital Status: Gender: Female edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Sam Fna 1937-12-30 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: Marital Status: Gender: Female Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Sam Fna 1937-12-30 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Age: Marital Status: Gender: Female Pesignation (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				from the	Tota	al amount:	
date of issue					To be paid by t	To be paid by the patient	
Assignmeı	Assignment code			To be paid b insurance com		_	
			5. Det	ails Of Pa	ramedical Proced	ures:	
Date	te Code Designation (Medical acts)		acts)	Coefficier	nt Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5			exceed 5 days		Total amount		
from the o	date of iss	sue		To be	paid by the patient		
Assignment code				To be paid by the insurance company			
Patient	Patient signature Signature and stamp medical Healthcare centre Doctor				d stamp of the		
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)				ction Reserved			
No:		Drugs	Dosage (Dosage Quantity Total Cost			
1				3	0		
Important: The prescribing		Total am	ount: 3	0.00			

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 (%)	19.80
		To be paid by MAADO	10.20
Sig	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist