## **Medical Care Form**

Claim number: 3243535

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 G. 2000-06-18		Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Dhiraj G. 2000-06-18						
Age:	23.4		Prescribing Doctor / orientation: Otis MillBurn				
Marital Status :							
Gender :	Male						
4. Details Of Medical 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:  code	Access To Health Care  Matricule:  Nom: Carte ID: Full Name (first, middle, last): Age: 23.4  Marital Status: Gender: Male  Access To Health Care  Marital Status:  Dhiraj Carte ID:  Dhiraj Car	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Dhiraj G. 2000-06-18  Carte ID:  Full Name (first, middle, last):  Age:  Age:  23.4  Marital Status:  Gender:  Male  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhiraj G. 2000-06-18  Agreed healthcare  Full Name (first, middle, last):  Age:  23.4  Prescribing Docto Otis MillBurn  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 networ  Carte ID:  Full Name (first, middle, last):  Age:  23.4  Prescribing Doctor / orient Otis MillBurn  Marital Status:  Gender:  Male  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		fos Referen	ce Medical	
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	l amount:
date of iss	sue				То	be paid by th	ne patient
Assignment code				To be paid by the insurance company			
			5. Det	ails Of Pa	ramedi	ical Procedu	res:
Date	Code	Designation (Medical acts)		Coefficier	nt Ra	Rate Total Cost	
Important: The validity of this form cannot excee			exceed 5 days		То	tal amount:	
from the o	date of issue			To be	paid by	the patient	
Assignment code				To be pa	aid by the insurance company		
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor				
Prescribed (Section Reserved For The				dicines ribing	Section Reserved For The Pharmacist		
No:	Dr	ugs	Dosage	QuantityT	otal Co	st	
1		processor		0			
			Total am	ount: 0	.00		
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
		To be paid by MAADO	0.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist