Medical Care Form

Claim number:y6y6

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		al	
Matricule:			Date and Time:			
Nom:	prashant kumar 1998-10- 28		Agreed healthcare network:			
Carte ID:	574372					
Full Name (first, middle, last):	prashant kumar 1998-10- 28					
Age:	24.8		Prescribing Doctor / orientation: rg rg rg			
Marital Status :						
Gender :	Male					
edical Procedures:						
Code	Designation (Medical acts)		Coefficient	Rate	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: Full Name (first, middle, prashandlast): Age: Age: Gender: Male Male edical Procedures:	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: 24.8 Marital Status: Gender: Male Mrite legibly ID obligatoire 2. Patient Policy Age: 24.8 Marital Status: Male	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: 24.8 Prescribing Doctorg rg rg Marital Status: Gender: Male Mrite legibly ID obligatoire 3. Infos Reference Center Agreed healthcare Policy Patient Policy Patient Policy Agreed healthcare Prescribing Doctorg rg rg Male	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Prashant kumar 1998-10-28 Carte ID: Full Name (first, middle, last): Age: Age: 24.8 Prescribing Doctor / orienting rg rg rg Marital Status: Gender: Male Mrite legibly ID obligatoire 3. Infos Reference Medica Center Agreed healthcare networe Agreed healthcare networe Prescribing Doctor / orienting rg rg rg Marital Status: Gender: Male	

<u>Important:</u> The validity of this form cannot	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			Infos Referen enter	ce Medical		
<u>Important</u>	<u>t:</u> The validit	y of this form cannot (exceed 5 days 1	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code						To be paid by the insurance company		
			5. Det	ails Of Pa	ıramı	edical Procedu	ıres:	
Date	Code Designation (Medical acts)		acts)	Coefficie	nt	Rate Total Cost		
-	Important: The validity of this form cannot exceed 5 da					Total amount:		
from the (date of issue	2		To be	paid	by the patient		
Assignment code				To be pa	aid by the insurance company			
Patient	signature	Signature and stamp medical Healthcare centre Doctor			l stamp of the			
Prescribed (Section Reserved For The			dicines	Section Reserved or The Pharmacist				
No:	Dru	ugs	Dosage	QuantityT	otal	Cost		
I		Total am	ount: r	ınt: null				
Important: The prescribing practitioner will		To be pa the patie	T I	Intill				

	icate the duration of treatment for Section Reserved For g,	6. Medicines The Prescribing	Section Reserved For The Pharmacist	
and its vali		To be paid by MAADO	null	
Signatu	re and stamp Prescribing Doctor	Signature and stamp Pharmacist		