Medical Care Form

Claim number: wewewe

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					
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: 549050 Full Name (first, middle, last): Age: Age: 86.0 Marital Status: Gender: Female edical Procedures: Designation	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: Marital Status: Gender: Female Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Sam Fna 1937-12-30 Carte ID: Full Name (first, middle, last): Age: Age: Marital Status: Gender: Female 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		Infos Referen nter	ce Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	ıl amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by th insurance compan				
			5. Det	ails Of Pa	rame	dical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coefficie	nt	Rate Total Cost		
Important: The validity of this form cannot exceed		exceed 5 days			Total amount:			
from the o	date of issue			To be	paid l	by the patient		
Assignment code				To be pa	be paid by the insurance company			
Patient	Patient signature Signature and stamp medical Heal			hcare centre Doctor				
Prescribed (Section Reserved For The			dicines	Section Reserved				
No:	Dr	ugs	Dosage(QuantityT	otal (Cost		
1		processor		2	20			
			Total am	ount: 2	20.00			
Important: The prescribing				_				

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 (%)	13.20
		To be paid by MAADO	6.80
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist