## **Medical Care Form**

Claim number:

| 1. Health Insurance System Information |  | Filling Instructions  |  |   |   |  |
|--|--|---|--|---|---|--|
| SAM code:                              |  | Write legibly   |  |   |   |  |
| SAM:                                   |  |   | ID obligatoire   |   |   |  |
| Information & Access To Health Care    |  | 2. Patient Center Policy  |  | e Medica  | al  |  |
| Matricule:                             | Prashant 2000-10-10  |   | Date and Time:   |   |   |  |
| Nom:                                   |  |   | Agreed healthcare network:   |   |   |  |
| Carte ID:                              |  |   |  |   |   |  |
| Full Name (first, middle,<br>last):    | Prashant 2000-10-10  |   |  |   |   |  |
| Age:                                   | 23.3   |   | Prescribing Doctor / orientation:<br>Otis MillBurn   |   |   |  |
| Marital Status :                       |  |   |  |   |   |  |
| Gender :                               | Male   |   |  |   |   |  |
| 4. Details Of Medical Procedures:      |  |   |  |   |   |  |
| Code                                   | Designation (Medical acts)   |   | Coefficient  | Rate  | Total<br>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: Prashar  Carte ID:  Full Name (first, middle, last):  Age: 23.3  Marital Status :  Gender : Male  edical Procedures:  Code  Designation | Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Prashant 2000-10-10  Carte ID: Full Name (first, middle, last): Age: 23.3  Marital Status: Gender: Male  edical Procedures:  Designation (Medical | Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare  Full Name (first, middle, last):  Age:  Age:  23.3  Prescribing Docto Otis MillBurn  Marital Status:  Gender:  Male  Designation (Medical Coefficient | Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  Age:  23.3  Prescribing Doctor / orien Otis MillBurn  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                 |  | nfos Referen<br>Iter             | ce Medical                |            |  |
|---|----------------|----------------------------|-----------------------------------|--|----------------------------------|---------------------------|------------|--|
|   |                |                            |                                   |  |                                  |                           |            |  |
| <u>Important</u>  | :: The validit | ry of this form cannot e   | exceed 5 days 1                   | from the                               |                                  | Tota                      | il amount: |  |
| date of issue   |                |                            |                                   |  |                                  | To be paid by the patient |            |  |
| Assignment code   |                |                            |                                   | To be paid by the<br>insurance company |                                  |                           |            |  |
|   |                |                            | 5. Det                            | ails Of Pa                             | ramed                            | lical Procedu             | res:       |  |
| Date  | Code           | Designation (Medical acts) |                                   | Coefficie                              | nt R                             | Rate Total Cost           |            |  |
|   |                |                            |                                   |  |                                  |                           |            |  |
|   |                |                            |                                   |  |                                  |                           |            |  |
|   |                |                            |                                   |  |                                  |                           |            |  |
| <u>Important:</u> The validity of this form cannot exceed |                |                            | exceed 5 days                     |  | To                               | otal amount:              |            |  |
| from the o  | date of issue  |                            |                                   | To be                                  | paid by                          | y the patient             |            |  |
| Assignment code   |                |                            |                                   | To be pa                               | paid by the insurance<br>company |                           |            |  |
| Patient signature Signature and stamp medical Heal        |                |                            | Signature and stamp of the Doctor |  |                                  |                           |            |  |
| Prescribed (Section Reserved For<br>The                   |                |                            | dicines<br>ribing                 | Section Reserved<br>For The Pharmacist |                                  |                           |            |  |
| No:   | Dr             | ugs                        | Dosage(                           | QuantityT                              | otal Co                          | ost                       |            |  |
| 1   |                | processor                  |                                   | 8                                      | 00                               |                           |            |  |
|   |                |                            | Total am                          | ount: 8                                | 00.00                            |                           |            |  |
| Important: The prescribing                                |                |                            | <u> </u>                          |  |                                  |                           |            |  |

| Prescrik<br>each<br>Doctor) | practitioner will<br>ped (Section Reserved For<br>indicate the duration of treatment for<br>drug, | 6. Medicines The Prescribing     | Section Reserved<br>For The Pharmacist |
|-----------------------------|---|----------------------------------|--|
| and                         | this form is valid only for one pharmacy  | To be paid by<br>the patient (%) | 160.00                                 |
|                             |   | To be paid by<br>MAADO           | 640.00                                 |
| Sigi                        | nature and stamp Prescribing Doctor   | Signa                            | ture and stamp Pharmacist              |