Medical Care Form

Claim number:123

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:	Prashant 2024-03-01		Agreed healthcare network:				
Carte ID:	7807						
Full Name (first, middle, last):	Prashant 2024-03-01						
Age:	0.0		Prescribing Doctor / orientation: fsd fsdf sdf				
Marital Status :							
Gender :	Male						
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: Prashar Carte ID: 7807 Full Name (first, middle, last): Age: 0.0 Marital Status : Gender : Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2024-03-01 Carte ID: 7807 Full Name (first, middle, last): Age: 0.0 Marital Status: Gender: Male edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2024-03-01 Full Name (first, middle, last): Age: O.0 Prescribing Docto fsd fsdf sdf Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2024-03-01 Agreed healthcare networ Carte ID: 7807 Full Name (first, middle, last): Age: 0.0 Prescribing Doctor / orient fsd fsdf sdf 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	

nformation & Access To Health Care		2. Patient Policy			3. Infos Reference Medical Center		
<u>.</u> <u>mportant:</u> The validity of this form cann	not excee	ed 5 days t	from the		Tota	al amount:	
ate of issue				-	Γο be paid by t	he patient	
Assignment code			To be paid by t insurance compa				
		5. Det	ails Of P	aramo	edical Procedu	ıres:	
Date Code Designation (Medi	Code Designation (Medical acts)		Coefficient		Rate	Total Cost	
<u>lmportant:</u> The validity of this form cannot exceed !					Total amount:		
rom the date of issue			To be	e paid	by the patient		
Assignment code			To be paid by the insurance company				
atient signature Signature and stamp medical Healthcare centre Doctor				d stamp of the			
rescribed (Section Reserved For		6. Med The Prescr	dicines	For Th	Seo ne Pharmacist	ction Reserved	
lo: Drugs		Dosage	Quantity	Total	Cost		
mayami		10 1	0	100			
Important: The prescribing		Total am	ount:	100.00)		

Prescril 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 (%)	20.00
		To be paid by MAADO	80.00
Sig	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist