Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center		al	
Matricule:			Date and Time:			
Nom:	Pranali 2000-10-11		Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Pranali 2000-10-11					
Age:	23.3		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: Pranali Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Female edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Pranali 2000-10-11 Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Female edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Pranali 2000-10-11 Agreed healthcar Carte ID: Full Name (first, middle, last): Age: Age: 23.3 Prescribing Doctor dhiraj gurve Marital Status: Gender: Female Designation (Medical Coefficient	Write legibly D obligatoire	

<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		3. Infos Reference Medical Center			
					T			
<u>lmportan</u>	<u>t:</u> The validi	ty of this form cannot e	exceed 5 days	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by insurance compa				
			5. Det	ails Of Pa	ram	edical Procedu	ıres:	
Date	te Code Designation (Medical acts)		acts)	Coefficie	nt	Rate	Total Cost	
<u>lmportant:</u> The validity of this form cannot exceed			exceed 5 days			Total amount:		
from the	date of issu	e		To be	paid	by the patient		
Assignment code				To be pa	o be paid by the insurance company			
Patient	Signature and stamp medical Healthcare centre Doctor			_	l stamp of the			
Prescribe Doctor)	ed (Section F	Reserved For	6. Med The Prescr	dicines ribing	or Tl	Sed ne Pharmacist	ction Reserved	
No:	Dr	ugs	Dosage(Quantity Total Cost				
1				1	60			
Important: The prescribing		Total am	ount: 1	160.00				

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 (%)	160.00
		To be paid by MAADO	0.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist