

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 Policy		3. Infos Reference Medical Center
Primary insured	Matricule:		Date and Time:		
	Nom:	Prashant 2000-10-10	Agreed healthcare network:		
Patient	Carte ID:				
	Full Name (first, middle, last):	Prashant 2000-10-10			
	Age:	23.3	Prescribing Doctor / orientation: fgweg weg weg		
	Marital Status :				
	Gender :	Male			
4. Details Of Medical Procedures:					
Date	Code	Designation (Medical acts)	Coefficient	Rate	Total Cost

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue	Total amount:		
	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	
Important: The validity of this form cannot exceed 5 days from the date of issue			Total amount:			
			To be paid by the patient			
Assignment code			To be paid by the insurance company			
5. Details Of Paramedical Procedures:						
Date	Code	Designation (Medical acts)	Coefficient	Rate	Total Cost	
Important: The validity of this form cannot exceed 5 days from the date of issue			Total amount:			
			To be paid by the patient			
Assignment code			To be paid by the insurance company			
Patient signature		Signature and stamp medical Healthcare centre		Signature and stamp of the Doctor		

Prescribed (Section Reserved For Doctor)			6. Medicines The Prescribing		Section Reserved For The Pharmacist	
No:	Drugs	Dosage	Quantity	Total Cost		
1	tramadol eg l.p. 200 mg, comprimé à libération prolongée	10	100	1000		

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist
2	perindopril tosilate teva 10 mg, comprimé pelliculé	10	10	100
3	perindopril tosilate teva 10 mg, comprimé pelliculé	10	100	1000
<p><u>Important:</u> The prescribing practitioner will indicate the duration of treatment for each drug, and this form is valid only for one pharmacy and its validity cannot exceed 72 hours after delivery</p>		Total amount:		2100.00
		To be paid by the patient (%)		420.00
		To be paid by MAADO		1680.00
Signature and stamp Prescribing Doctor		 Signature and stamp Pharmacist		