## **Medical Care Form**

Claim number:1212

1. Health Insurance System Information		Filling Instructions			
SAM code:		Write legibly			
SAM:		ID obligatoire			
Information & Access To Health Care		2. Patient	3. Infos Reference Medical Center		
Matricule:			Date and Time:		
Nom:			Agreed healthcare network:		
Carte ID:	569161				
Full Name (first, middle, last):	Lindsay Laura 1973-02-12				
Age:	50.7		Prescribing Doctor / orientation: wer wer wer		
Marital Status :					
Gender :	Female				
edical Procedures:					
LOGE	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:  Full Name (first, middle, last):  Age:  Age:  Gender:  Gender:  Female  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Lindsay Laura 1973-02-12  Carte ID: 569161  Full Name (first, middle, last): Age: 50.7  Marital Status: Gender: Female  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Lindsay Laura 1973-02-12 Agreed healthcare Carte ID:  Full Name (first, middle, last):  Age:  Age:  Marital Status:  Gender:  Female  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Lindsay Laura 1973-02-12 Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  Age:  Designation (Medical Coefficient Rate

<u>Important:</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. Pati Policy		3. Infos Referer Center	nce Medical	
<u>lmporta</u> ı	<u>nt:</u> The val	lidity of this form cannot e	exceed 5 days	from the	Tota	al amount:
date of i	ssue				To be paid by t	he patient
Assignment code				To be paid by the insurance company		
	5. Details Of Paramedical Procedures:				ures:	
Date	Code	Designation (Medical	Designation (Medical acts)		nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5 o		exceed 5 days		Total amount		
from the	date of is	ssue		To be լ	paid by the patient	
Assignm	ent code			To be pai	d by the insurance company	
Patien	t signatur	e Signature and stamp	Signature and stamp medical Healthcare centre Doctor			d stamp of the
One of the prescribed (Section Reserved For The Prescribing Prescr						
No: Drug	S		Dosage	QuantityT	otal Cost	
	prazole sa ispersible	ındoz 10 mg, comprimé	222	2 4		
	1	A. The many matters	Total an	nount: 4	.00	
Important: The prescribing			1			

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 (%)	3.92
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.08
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist