


# 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:                             |                            | Agreed healthcare network:                        |      |                                   |
| Patient                                | Carte ID:                        |                            |   |      |                                   |
|  | Full Name (first, middle, last): |                            |   |      |                                   |
|  | Age:                             |                            | Prescribing Doctor / orientation:<br>fsd fsdf sdf |      |                                   |
|  | Marital Status :                 |                            |   |      |                                   |
|  | Gender :                         |                            |   |      |                                   |
| 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 |  |
|   |           |   |                                     |                                   |                                   |  |
| <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 |                                   |                                   |  |
| 5. Details Of Paramedical 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 |                                   |                                   |  |
| Patient signature   |           | Signature and stamp medical Healthcare centre |                                     | Signature and stamp of the Doctor |                                   |  |
| 6. Medicines Prescribed (Section Reserved For The Doctor)                               |           |   | Section Reserved For The Pharmacist |                                   |                                   |  |
| No:   | Drugs     | Dosage  | Quantity                            | Total Cost                        |                                   |  |
| 1   | imaging 1 | 10  | 10                                  | 1000                              |                                   |  |
| <u>Important:</u> The prescribing   |           | Total amount:                                 |                                     | 1000.00                           |                                   |  |
|   |           |   |                                     |                                   |                                   |  |

|  |  |   |
|--|--|---|
| <p>practitioner will</p> <p><b>Prescribed (Section Reserved For</b></p> <p>indicate the duration of treatment for</p> <p>each</p> <p><b>Doctor)</b></p> <p>drug,</p> | <p><b>6. Medicines</b></p> <p><b>The</b></p> <p><b>Prescribing</b></p>   | <p><b>Section Reserved</b></p> <p><b>For The Pharmacist</b></p> |
| <p>this form is valid only for one pharmacy</p> <p>and</p> <p>its</p> <p>validity cannot exceed 72 hours after</p> <p>delivery</p>                                   | <p>To be paid by</p> <p>the patient (%)</p>  | <p>200.00</p>   |
|  | <p>To be paid by</p> <p>MAADO</p>  | <p>800.00</p>   |
| <p>Signature and stamp Prescribing Doctor</p>  | <p></p> <p>Signature and stamp Pharmacist</p> |   |