Medical Care Form

Claim number:34f34f

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:			
rimary nsured Nom: Laura Marhysa 1978-0 20		larhysa 1978-01-	Agreed healthcare network:			
Carte ID:	594565					
	Laura Marhysa 1978-01- 20					
Age:	45.8		Prescribing Doctor / orientation: f34f 34f 34f			
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: Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Marital Status: Gender: Female Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): 20 Age: 45.8 Prescribing Docto f34f 34f 34f Marital Status: Gender: Female Posignation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctor / orient f34f 34f 34f Marital Status: Gender: Female Designation (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	

Information & Access To Health Care		2. Pati Policy		3. Infos Referer Center	nce Medical	
<u>lmporta</u>	nt: The va	lidity of this form cannot e	exceed 5 days	from the	Tot	al amount:
date of i	ssue				To be paid by t	the patient
Assignment code				To be paid by the insurance company		· .
			5. Det	ails Of Pa	ramedical Proced	ures:
Date	Code	Designation (Medical	Designation (Medical acts)		nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5 c		exceed 5 days		Total amount	:	
from the	date of is	ssue		To be	paid by the patien	t
Assignm	ent code			To be pa	id by the insurance company	
Patien	it signatur	re Signature and stamp	Signature and stamp medical Healthcare centre Doctor			d stamp of the
Prescribed (Section Reserved For The Prescribing Doctor) 6. Medicines Section Reserve For The Pharmacist						
No: Drug	gs		Dosage	Quantity ⁻	Гotal Cost	
-	prazole sa lispersible	andoz 10 mg, comprimé	32	32 [*]	1024	
	I	. The same of the	Total an	nount: I	null	
Important: The prescribing						

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