Medical Care Form

Claim number: 4565467

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:			
Nom:			Agreed healthcare network:			
Carte ID:	32332					
Full Name (first, middle, last):	dhiraj 2001-10-10					
Age:	22.3		Prescribing Doctor / orientation: gjh hjkhjk kj			
Marital Status :						
Gender :	Male					
4. Details Of Medical Procedures:						
Lone	Designation (Medical acts)		Coefficient	IRate	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: dhiraj 2 Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Marital Status : Gender : Male Edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Marital Status: Gender: Male Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: dhiraj 2001-10-10 Agreed healthcare Full Name (first, middle, last): Age: 22.3 Prescribing Docto gjh hjkhjk kj Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: dhiraj 2001-10-10 Agreed healthcare networ Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Prescribing Doctor / orient gjh hjkhjk kj Marital Status: Gender: Male 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. Patient Policy		Infos Referen enter	ce Medical	
<u>Important</u>	<u>::</u> The validit	y of this form cannot e	exceed 5 days	from the		Tota	al amount:
date of iss	sue				Т	o be paid by t	he patient
Assignment code				To be paid by the insurance company			
			5. Det	ails Of Pa	ırame	edical Procedu	ıres:
Date	Code Designation (Medical acts)		acts)	Coefficie	Coefficient Rate		Total Cost
Important: The validity of this form cannot exceed			exceed 5 days			Total amount:	
from the o	date of issue			To be	paid	by the patient	
Assignment code				To be pa	aid by the insurance company		
Patient	nt signature Signature and stamp medical Heal			Signature and stamp of the Doctor			
Prescribe	d (Section R	eserved For	6. Med The Presci	dicines ribing	or Th	Seo ne Pharmacist	ction Reserved
No:	Drugs		Dosage	Quantity 1	otal (Cost	
1	uarrrr	rr	0 0) ()		
	•		Total am	ount: 0	0.00		
Important: The prescribing			1				

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