Medical Care Form

Claim number: gdhg

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
		ID obligatoire					
Access To Health Care	2. Patient		3. Infos Reference Medical Center				
Matricule: Primary nsured Nom:			Date and Time:				
		15151 2023-09-02	Agreed healthcare network:				
Carte ID:	22						
	Suyesh	15151 2023-09-02					
Age:	0.3		Prescribing Doctor / orientation:				
Marital Status :							
Gender :	Male						
4. Details Of Medical Procedures:							
l one	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender :	Access To Health Care Matricule: Nom: Suyesh Carte ID: 22 Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Suyesh 15151 2023-09-02 Agreed healthcare networ Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orient 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 Medica	ı		
Important: The validity of this form cannot exceed				xceed 5 days 1	ed 5 days from the		Total amount:		
date of issue				To be paid by the patient					
Assignment code						To be paid by the insurance company			
5. Det				5. Deta	ails Of Para	ıme	edical Procedu	res:	
Date	Code		Designation (Medical a	acts)	Coefficient		Rate	Total Cost	
<u>Important:</u> The validity of this form cannot ex			xceed 5 days			Total amount:			
from the date of issue		To be p		aid by the patient					
Assignment code			To be paid by the insurance company						
Patient signature Signature and stamp (medical Healthcare centr		Signature and stamp of the Doctor					
,,				6 Mag	licines				

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist
No:	Drugs	Dosage Quantity		Total Cost
1				100

Prescribed (Section Reserved For Doctor)			6. Medicines The Prescribing		Section Reserved For The Pharmacist
2					40
3					12000
each	Important: The prescribing practitioner will indicate the duration of treatment for		Total amount:		12140.00
and	drug, this form i	drug, this form is valid only for one pharmacy its validity cannot exceed 72 hours after delivery			8012.40
	validity ca				4127.60
Signature and stamp Prescribing Doctor				Signa	ture and stamp Pharmacist