## **Medical Care Form**

Claim number:qaqa

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center		al	
Matricule:			Date and Time:	Time:		
Nom:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto qa qa qa	r / orien	tation:	
Marital Status :						
Gender :						
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:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  edical Procedures:  Designation	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status:  Gender:  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status:  Gender:  Code  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  Age:  Marital Status:  Gender:  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		3. Infos Referen Center	ice Medical		
<u>lmportar</u>	ı <u>t:</u> The validit	y of this form cannot e	exceed 5 days	s from the		Tota	al amount:	
date of issue				To be paid			by the patient	
Assignment code				To be paid by th insurance compar				
			5. D€	tails Of P	aram	nedical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coeffici	ent	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed from the date of issue			exceed 5 days	5		Total amount:		
				To be pa		d by the patient		
Assignment code			To be p	e paid by the insurance company				
Patien	t signature	Signature and stamp medical Healthcare centre Doctor				d stamp of the		
Prescribed (Section Reserved For			The	edicines cribing	Section Reserved For The Pharmacist			
No:	Drugs		Dosage	Quantity	Tota	l Cost		
1	eyeglass exc	rel 2	3		9			
		·			9.00			
<u>Important:</u> The prescribing		ne prescribing						

Prescrib 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 (%)	1.80
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	7.20
Sign	nature and stamp Prescribing Doctor	Signat	ture and stamp Pharmacist