Medical Care Form

Claim number:

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			е				
Information & Access To Health Care			3. Infos Reference Medical Cente				
Matricule:			Date and Time:				
ry ded Nom: prashant 1 2024		1 2024-02-04	Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	prashant [•]	1 2024-02-04					
Age:	0.0		Prescribing Doctor / orientation: mentor Dental prashant				
Marital Status :							
Gender :	Male						
ledical Procedures:							
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Iedical Procedures:	Matricule: Nom: prashant for the state of t	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: prashant 1 2024-02-04 Carte ID: Full Name (first, middle, last): Age: O.0 Marital Status: Gender: Male Medical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Date and Time: Nom: Prashant 1 2024-02-04 Agreed healthcare not prashant 1 2024-02-04 Full Name (first, middle, last): Age: O.0 Prescribing Doctor / mentor Dental prash Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: prashant 1 2024-02-04 Agreed healthcare network: Carte ID: Full Name (first, middle, last): Age: 0.0 Prescribing Doctor / orientati mentor Dental prashant Marital Status: Gender: Male Designation (Medical Coefficient Rate		

<u>lmportant:</u> The validity of this form canno	Total amount:		
the date of issue		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Informat	mation & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center		
<u>Importan</u>	<u>t:</u> The validit	y of this form canno	ot exceed	d 5 days	from		Tota	l amount:
the date of issue						To be paid by the patient		
Assignment code					To be paid by the insurance company			
				5. Det	ails Of P	arame	edical Procedu	ıres:
Date	ce Code Designation (Medical acts)				Coeffici	ent Rate Total Cost		
Important: The validity of this form cannot exceed 5			d 5 days			Total amount:		
from the	date of issue	•			To be	e paid	by the patient	
Assignment code			To be p	pe paid by the insurance company				
Patient	signature	Signature and stamp medical Healthcare o				Signature and stamp of the Doctor		
Prescribed (Section Reserved For The			dicines	Section Reserved For The Pharmacist				
No:	Drugs			Dosage (Quantity	Total	Cost	
1	уууууууу		1 ′	10	120			
_	1			Total am	ount:	ount: 120.00		
<u>Important:</u> 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 (%)	120.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Sig	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist