## **Medical Care Form**

Claim number:

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:				
Nom:	Dhiraj G. 2000-06-18		Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Dhiraj G. 2000-06-18						
Age:	23.4		Prescribing Doctor / orientation:				
Marital Status :							
Gender :	Male						
edical 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:  edical Procedures:	Access To Health Care  Matricule:  Nom: Carte ID: Full Name (first, middle, last): Age: 23.4  Marital Status: Gender: Male  edical Procedures:  Code  Designation	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Dhiraj G. 2000-06-18  Carte ID: Full Name (first, middle, last): Age: 23.4  Marital Status: Gender: Male  edical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhiraj G. 2000-06-18  Agreed healthcare  Carte ID:  Full Name (first, middle, last):  Age:  Age:  23.4  Prescribing Docto  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Dhiraj G. 2000-06-18  Agreed healthcare netword  Carte ID:  Full Name (first, middle, last):  Age:  2. Patient Policy  Date and Time:  Agreed healthcare netword  Agreed healthcare netword  Prescribing Doctor / orient  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate		

<u>Important:</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>	:: The validit	ty of this form cannot e	exceed 5 days 1	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	arame	edical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coefficie	nt	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	paid by the insurance company			
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The				dicines dibing	Section Reserved			
No:	Dr	ugs	Dosage	Quantity	Total (	Cost		
1					100			
	•		Total am	nount: 100.00				
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 (%)	0.00
		To be paid by MAADO	100.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist