Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions			
SAM code:		Write legibly			
		ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center		al
Matricule:			Date and Time:		
Nom:	Pranali 2000-10-11		Agreed healthcare network:		
Carte ID:					
Full Name (first, middle, last):	Pranali 2000-10-11				
Age:	23.3		Prescribing Doctor / orientation: dhiraj gurve		
Marital Status :					
Gender :	Female				
edical 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 : edical Procedures:	Access To Health Care Matricule: Nom: Pranali Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Female edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Pranali 2000-10-11 Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Female edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Pranali 2000-10-11 Agreed healthcar Carte ID: Full Name (first, middle, last): Age: Age: 23.3 Prescribing Doctor dhiraj gurve Marital Status: Gender: Female Designation (Medical Coefficient	Write legibly D obligatoire

<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 Reference Medical Center	
Important: The validity of this form cannot exceed			exceed 5 days	from the	Tot	al amount:
date of issue					To be paid by the patient	
Assignmeı	Assignment code			To be paid by insurance comp		
			5. Det	ails Of Par	amedical Proced	ures:
Date	te Code Designation (Medical acts)		acts)	Coefficien	t Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed !			exceed 5 days		Total amount	
from the o	date of iss	sue		To be բ	oaid by the patien	t
Assignment code				To be paid by the insurance company		
Patient	Patient signature Signature and stamp medical Healthcare centre Doctor			d stamp of the		
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)				ction Reserved		
No:		Drugs	Dosage (QuantityTo	otal Cost	
1				66	50	
Important: The prescribing		Total am	ount: 66	50.00		

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 (%)	660.00
		To be paid by MAADO	0.00
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist	