Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions					
SAM code:			Write legibly				
SAM:			ID obligatoire				
Access To Health Care		2. Patient Center Policy		e Medica	al		
Matricule:			Date and Time:				
Nom:	prashant 1 2024-02-0		Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	prashant 1 2024-02-04						
Age:	0.0		Prescribing Doctor / orientation: jorge soros				
Marital Status :							
Gender :	Male						
4. Details Of Medical 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: prashar Carte ID: Full Name (first, middle, last): Age: 0.0 Marital Status : Gender : Male edical Procedures: Code Designation	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 edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: prashant 1 2024-02-04 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: 0.0 Prescribing Docto jorge soros Marital Status: Gender: Male Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 1 2024-02-04 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: O.0 Prescribing Doctor / orien jorge soros 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	

Informati	nformation & Access To Health Care			2. Patient Policy			. Infos Referen enter	ce Medical	
Important: The validity of this form cannot excee			ed 5 days 1	from the		Tota	al amount:		
date of issue							To be paid by the patient		
Assignment code				To be paid insurance cor		-			
5. Details Of Paramedical Procedures:						ıres:			
Date	Date Code Designation (Medical acts)			Coefficie	pefficient Rate T		Total Cost		
Important: The validity of this form cannot exceed			ed 5 days			Total amount:			
from the date of issue				To be	e paid	by the patient			
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor						
Prescribed (Section Reserved For The			6. Med The Prescr	Section Reserved For The Pharmacist					
No:	Drugs Dosa		Dosage)uantity	Total	al Cost			
1						26			
<u>lr</u>	Important: The prescribing			Total am	ount:	26.00			

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 (%)	26.00
		To be paid by MAADO	0.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist