## **Medical Care Form**

Claim number:

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
		ID obligatoire				
Access To Health Care			3. Infos Reference Center	e Medica	al	
Matricule:			Date and Time:			
Nom:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto sdf sdf sdf	r / orien	tation:	
Marital Status :						
Gender :						
4. Details Of Medical Procedures:						
l one	Designa acts)	ation (Medical	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:  Age:  Age:  Cender  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:  Prescribing Doctor / orient sdf sdf sdf  Marital Status:  Gender:  edical Procedures:  Code  Designation (Medical Coefficient Rate	

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		To be paid by the patient	
Assignment code		To be paid by the insurance company	

<u>Important:</u> The validity of this form car	nnot excee	ed 5 days t	from the		Tota	al amount:	
date of issue					To be paid by t	he patient	
Assignment code		To be paid by the insurance company					
		5. Det	ails Of Pa	aram	edical Procedu	ıres:	
Date Code Designation (Me	Designation (Medical acts)		Coefficient Rate		Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed					Total amount:		
from the date of issue			To be	paid	by the patient		
Assignment code			To be paid by the insurance company				
Patient signature Signature and stamp medical Heal			thcare centre Doctor				
Prescribed (Section Reserved For Doctor)		6. Med The Prescr	dicines	For T	Seo he Pharmacist	ction Reserved	
No: Drugs		Dosage (	Quantity	Total	Cost		
1 image		10 1	0	100			
<u>Important:</u> The prescribing		Total am	ount:	100.0	0		

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 (%)	20.00
		To be paid by MAADO	80.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist