Medical Care Form

Claim number:qaqa

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto qa qa qa	r / orien	tation:	
Marital Status :						
Gender :						
4. Details Of Medical 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 :	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: Marital Status: Gender: Code 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: Marital Status: Gender: 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	

Information & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center			
<u>Important:</u> ⁻	The validity	y of this form cannot e	exceed 5 days 1	from the		Tota	l amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Deta	ails Of Pa	ramed	ical Procedu	res:	
Date C	ode	Designation (Medical acts)		Coefficie	nt R	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed from the date of issue			xceed 5 days		To	otal amount:		
				To be	paid by	aid by the patient		
Assignment code				To be pa	id by the insurance company			
Patient si	Patient signature Signature and stamp medical Heal			Signature and stamp of the Doctor				
Prescribed (Section Reserved For The			6. Med The Prescr	licines ribing	Section Reserved			
No:	Dru	ıgs	DosageC	Quantity T	otal Co	st		
1	gfjh	1	1 1	1				
<u>Important:</u> The prescribing		Total am	ount: 1	.00				

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 (%)	0.40
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.60
Sign	nature and stamp Prescribing Doctor	Signat	ture and stamp Pharmacist