## **Medical Care Form**

Claim number: 345

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:			Agreed healthcare	e networ	·k:	
Carte ID:						
Full Name (first, middle, last):						
Age:			Prescribing Docto 534 345 34	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 :  edical Procedures:	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:  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:  Prescribing Doctor / orien 534 345 34  Marital Status:  Gender:  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	

nformation & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center		
<u>lmportar</u>	<u>nt:</u> The validit	y of this form cannot e	exceed 5 days	from the		Tota	al amount:
date of is	ssue				-	Го 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 (Medical acts)		acts)	Coefficient		Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days			Total amount:	
from the	date of issue			To be	paid	by the patient	
Assignment code				To be pa	oaid by the insurance company		
Patien	Patient signature Signature and stamp medical Healt			thcare ce	Signature and stamp of the Doctor		
Prescribo	ed (Section R	eserved For	6. Med The Presci	dicines ribing	For Tl	Se he Pharmacist	ction Reserved
No:	Drugs		Dosage	Quantity	Total	Cost	
1	afrom excel	1qq	1 1	l	1		
	•		Total am	ount:	1.00		
Important: The prescribing							

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	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		