Medical Care Form

Claim number :rf

| 1. Health Insurance System Information | | Filling Instructions | | | | |
|--|--|---|---|--|--|--|
| SAM code: | | | Write legibly | | | |
| SAM: | | | ID obligatoire | | | |
| Information & Access To Health Care | | 2. Patient | 3. Infos Reference Medical Center | | | |
| Matricule: | | | Date and Time: | | | |
| Nom: | Suyesh 15151 2023-09-02 | | Agreed healthcare network: | | | |
| Carte ID: | 22 | | | | | |
| Full Name (first, middle, last): | Suyesh | 15151 2023-09-02 | | | | |
| Age: | 0.3 | | Prescribing Doctor / orientation: | | | |
| Marital Status : | | | | | | |
| Gender : | Male | | | | | |
| 4. Details Of Medical Procedures: | | | | | | |
| Loge | Designation (Medical acts) | | Coefficient | IRate | 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: 22 Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male Addical Procedures: Code Designa | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Male dical Procedures: Code Designation (Medical | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient | Write legibly ID obligatoire 2. Patient Center Matricule: Date and Time: Nom: Suyesh 15151 2023-09-02 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orient 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 | |

| Information & Access To Health Care | | | 2. Patient Policy | | nfos Referen nter | ce Medical | | |
|--|------|-------------------------------|----------------------|--|------------------------------------|--------------------------------------|------------|--|
| | | | | | | | | |
| Important: The validity of this form cannot excee | | | exceed 5 days 1 | d 5 days from the | | Tota | il amount: | |
| date of issue | | | | | | To be paid by the patient | | |
| Assignment code | | | | To be paid by the insurance company | | | | |
| | | | 5. Det | ails Of Pa | ramed | dical Procedu | res: | |
| Date | Code | de Designation (Medical acts) | | Coefficie | nt F | Rate Total Cost | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| <u>Important:</u> The validity of this form cannot exceed 5 from the date of issue | | | exceed 5 days | | Т | otal amount: | | |
| | | | | To be | paid b | aid by the patient | | |
| Assignment code | | | | To be pa | e paid by the insurance company | | | |
| Patient signature Signature and stamp medical Healthcare co | | | | thcare ce | ntre I | Signature and stamp of the Doctor | | |
| Prescribed (Section Reserved For The | | | dicines ribing | Section Reserved For The Pharmacist | | | | |
| No: | Dr | ugs | Dosage | QuantityT | otal C | ost | | |
| 1 | | | | 4 | 200 | | | |
| | | | Total am | ount: 4 | 200.00 |) | | |
| Important: The prescribing | | | <u> </u> | | | | | |

| Prescril each Doctor) | practitioner will bed (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 (%) | 2772.00 |
| | | To be paid by MAADO | 1428.00 |
| Sig | nature and stamp Prescribing Doctor | Signa | ture and stamp Pharmacist |