Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
		ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:	Dhiraj G. 2000-06-18		Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Dhiraj G. 2000-06-18					
Age:	23.4		Prescribing Doctor / orientation:			
Marital Status :						
Gender :	Male					
edical 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: 23.4 Marital Status: Gender: Male edical Procedures: Code Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare netword Carte ID: Full Name (first, middle, last): Age: 2. Patient Policy Date and Time: Agreed healthcare netword Agreed healthcare netword 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		3. Infos Refere Center	ence Medical		
<u>lmportant:</u> The validity of this form cannot exceed 5 days date of issue			exceed 5 days t	from the	То	tal amount:	
					To be paid by the patient		
Assignment code					To be paid by the insurance company		
5. Details Of Paramedical Procedures:					dures:		
Date	Code	Designation (Medical a	acts)	Coefficient	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exc from the date of issue		exceed 5 days		Total amoun	t:		
			To be pai	d by the patie	nt		
Assignment code			To be paid by the insurance company				
Patient signature Signature and stamp medical Healthcare cent			Signature a Doctor	nd stamp of the			
	6. Medicines						

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
1				0

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist		
2					460	
	practition		Total amount:		460.00	
each and	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		0.00		
	its validity ca delivery		To be paid by MAADO		460.00	
Sig	gnature and	stamp Prescribing Doctor		Signa	ture and stamp Pharmacist	