## **Medical Care Form**

Claim number:t34t

1. Health Insurance System Information		Filling Instructions			
SAM code:		Write legibly			
SAM:		ID obligatoire			
Information & Access To Health Care		2. Patient Center Policy		e Medica	al
Matricule:	check checkCEHCKE 2023-		Date and Time:		
Nom:			Agreed healthcare network:		
Carte ID:	34				
Full Name (first, middle, last):	check ched 08-21	ckCEHCKE 2023-			
Age:	0.3		Prescribing Doctor / orientation:		
Marital Status :					
Gender :	Male				
Medical Procedures:					
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost
	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  Medical Procedures:	Matricule:  Nom: Carte ID: Age: Age: O.3 Marital Status: Gender: Male Medical Procedures:	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Check checkCEHCKE 2023- 08-21  Carte ID:  34  Full Name (first, middle, last):  Age:  0.3  Marital Status:  Gender:  Male  Medical Procedures:	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Check checkCEHCKE 2023- 08-21  Carte ID:  Full Name (first, middle, last):  Age:  0.3  Prescribing Docto  Marital Status:  Gender:  Male  Iedical Procedures:	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Check checkCEHCKE 2023- 08-21  Agreed healthcare netword 08-21  Full Name (first, middle, check checkCEHCKE 2023- 08-21  Age:  0.3  Prescribing Doctor / orient Marital Status:  Gender:  Male  Male

<u>Important:</u> The validity of this form canno	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. Pat Polic		3. Infos Refere Center	nce Medical		
<u>Important</u>	:: The validit	ry of this form canno	ot exceed 5 days	from the	Tot	tal amount:	
date of iss	sue				To be paid by	the patient	
Assignment code				To be paid by the insurance company			
			5. De	tails Of Pa	ramedical Proced	lures:	
Date	Code Designation (Medical acts)		Coefficier	nt Rate	Total Cost		
<u>Important:</u> The validity of this form cannot exceed		ot exceed 5 days		Total amoun	t:		
from the o	date of issue			To be	paid by the patien	t	
Assignment code			To be paid by the insurance company				
Patient	Patient signature Signature and stamp medical Healthca			lthcare cer	Signature and stamp of the Doctor		
6. Med Prescribed (Section Reserved For The Prescri			dicines	Section Reserved or The Pharmacist			
No:	Dr	ugs	Dosage	QuantityT	otal Cost		
1				4	0		
		ho muossiikiis -	Total ar	nount: 4	0.00	22222	
<u>Important:</u> The prescribing							

Prescrik 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 (%)	26.40
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	13.60
Signature and stamp Prescribing Doctor		Signat	ture and stamp Pharmacist