Medical Care Form

Claim number:zzz

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
		ID obligatoire						
Access To Health Care			e Medica	al				
Matricule:			Date and Time:					
Nom:	Dhiraj G	5. 2000-06-18	Agreed healthcare network:					
Carte ID:								
Full Name (first, middle, last):	Dhiraj G	5. 2000-06-18						
Age:	23.4		Prescribing Doctor / orientation: 45 45 45					
Marital Status :								
Gender :	Male							
4. Details Of Medical Procedures:								
l ode	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: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male Male Code Designa	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: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Full Name (first, middle, last): Age: 23.4 Prescribing Docto 45 45 45 Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly Dobligatoire			

<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 Refe	renc	e Medical		
Important: The validity of this form cannot exceed				xceed	d 5 days	from the		Т	otal	amount:	
date of issue								To be paid by the patient			
Assignment code					To be paid by the insurance company						
						5. Det	ails Of P	aran	nedical Proc	edur	es:
Date Code Designation (Medical acts)				Coefficient Rate		Т	otal Cost				
<u>Important:</u> The validity of this form cannot exceed		xceed	d 5 days			Total amou	ınt:				
from the date of issue			To be pa		e paid	d by the pati	ent				
Assignment code					To be paid by the insurance company						
Patient signature Signature and stamp medical Hea					ical Heal	Signature and stamp of the Doctor					
Prescribed (Section Reserved For Doctor)				6. Med The Presci	Section Reserved For The Pharmacist			tion Reserved			
No:	Drugs	5				Dosage (Quantity	Tota	l Cost		
1 gabapentine ranbaxy 400 mg, gélule			10	10	100	100					
						Total an	nount:	100.0	00		
Important: The prescribing		ŀ									

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 (%)	10.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	90.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist