Medical Care Form

Claim number:edf2w34

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		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	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	rame	dical Procedu	res:	
Date	Code	ode Designation (Medical acts)		Coefficie	nt F	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days		Т	otal amount:		
from the o	date of issue			To be	paid b	y the patient		
Assignment code				To be pa	e paid by the insurance company			
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The				dicines ribing	Section Reserved			
No:	Dr	ugs	Dosage(QuantityT	otal C	ost		
1		processor		9	80			
			Total am	ount: 9	80.00			
Important: The prescribing			<u> </u>					

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 (%)	646.80
		To be paid by MAADO	333.20
Sig	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist