## **Medical Care Form**

Claim number:45

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 Heal			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		processor		8	640			
			Total am	ount: 8	640.00	)		
Important: The prescribing			<u> </u>					

Prescrib each Doctor)	practitioner will 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 (%)	5702.40
		To be paid by MAADO	2937.60
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist