## **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:	sourabl	า 2000-11-23	Agreed healthcare network:				
Carte ID: 123  Full Name (first, middle, last): sourabh 2000-11-23							
		า 2000-11-23					
Age:			Prescribing Doctor / orientation: wef wef wef				
Marital Status :							
Gender :	Male						
edical 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: sourabl Carte ID: 123  Full Name (first, middle, last): Age: 23.2  Marital Status :  Gender : Male  Edical Procedures:  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: sourabh 2000-11-23  Carte ID: 123  Full Name (first, middle, last): Age: 23.2  Marital Status:  Gender: Male  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Sourabh 2000-11-23  Full Name (first, middle, last):  Age:  Age:  23.2  Prescribing Doctowef wef wef  Marital Status:  Gender:  Male  Designation (Medical  Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Sourabh 2000-11-23  Full Name (first, middle, last):  Age:  Age:  23.2  Prescribing Doctor / orient wef wef wef  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			Infos Referen nter	ce Medica	I		
<u>Important:</u> The validity of this form cannot exceed 5 days f			from the	Total amount:					
date of issue				To be paid by the patient					
Assignment code				To be paid by the insurance company					
5. Deta			ails Of Para	me	dical Procedu	ires:			
Date	Code		Designation (Medical a	acts)	Coefficient		Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue			exceed 5 days		1	Гotal amount։			
				id k	y the patient				
Assignment code			To be paid by the insurance company						
Patient signature Signature and stamp medical Healtho			thcare centr	$\sim$	Signature and Doctor	stamp of	the		
,									

Prescribed Doctor)	(Section Reserved For	The	edicines cribing	Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
1	vikas gupt	1	1	1

Prescribed (Section Reserved For Doctor)			edicines cribing	Section Reserved For The Pharmacist	
2	tomjerryhop	1	1	1	
	Important: The prescribing practitioner will indicate the duration of treatment for		nount:	2.00	
each and	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		0.40	
	validity cannot exceed 72 hours after delivery	To be paid by MAADO		1.60	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist			