Medical Care Form

Claim number:

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
	ID obligatoire							
Access To Health Care	2. Patient Policy		3. Infos Reference Medical Center					
Matricule:			Date and Time:					
Nom:	Prashar	nt 2000-10-10	Agreed healthcare network:					
Carte ID:								
Full Name (first, middle, last):	Prashar	nt 2000-10-10						
Age:	23.3		Prescribing Doctor / orientation: 234 234 234					
Marital Status :								
Gender :	Male							
edical Procedures:								
Lone	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: Prashar Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Male Access To Health Care Male Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2000-10-10 Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Male dical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2000-10-10 Agreed healthcare Full Name (first, middle, last): Age: 23.3 Prescribing Docto 234 234 234 Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 2000-10-10 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: 23.3 Prescribing Doctor / orient 234 234 234 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			3. Infos Reference Medical Center			
<u>Impo</u>	rtant:	The validity	y of this form cannot e	exceed 5 d	ays [·]	from the		Tota	al amount:
date of issue					To be paid by the patient			he patient	
Assignment code					To be paid by the insurance company				
				5.	Det	ails Of Pa	aram	edical Procedu	ıres:
Date	Date Code Designation (Medical acts)		acts)		Coefficient Rate		Rate	Total Cost	
Important: The validity of this form cannot exceed 5			exceed 5 d	ays			Total amount:		
from	the da	ate of issue				To be	paid	by the patient	
Assignment code			To be paid by the insurance company						
Pa	Patient signature Signature and stamp medical Heal				Heal	hcare centre Doctor			
Prescribed (Section Reserved For Th			ie	dicines ribing	Section Reserved For The Pharmacist				
No: D	rugs	Dosage			Quantity	Total Cost			
tramadol eg l.p. 200 mg, comprimé à libération prolongée			1		1	1			
				Tota	ıl an	nount:	1.00		
Important: The prescribing				 					

Prescril each Doctor)	practitioner will bed (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 (%)	0.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	1.00
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist