Medical Care Form

Claim number:123

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
inom,	Laura Marhysa 1978-01- 20		Agreed healthcare network:			
Carte ID:	594565					
	Laura Marhysa 1978-01- 20					
Age:	45.8		Prescribing Doctor / orientation: 13 13 13			
Marital Status :						
Gender :	Female					
edical Procedures:						
Lone	Designation (Medical acts)		Coefficient	Rate	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: 594565 Full Name (first, middle, laura Nation 20) Age: 45.8 Marital Status: Gender: Female Edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: 45.8 Marital Status : Gender : Female Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, laura Marhysa 1978-01-20 Age: 45.8 Prescribing Docto 13 13 13 Marital Status: Gender: Female Posignation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctor / orient 13 13 13 Marital Status: Gender: Female Pesignation (Medical Coefficient Rate	

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		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>lmportant:</u> The val	lidity of this form cannot e	exceed 5 days	from the		Tota	al amount:	
date of issue				-	Γο be paid by t	he patient	
Assignment code			To be paid by th insurance compar				
		5. Det	ails Of Pa	aramo	edical Procedu	ıres:	
Date Code	Code Designation (Medical acts)		Coefficient		Rate	Total Cost	
<u>lmportant:</u> The validity of this form cannot exceed					Total amount:		
from the date of is	ssue		To be	paid	by the patient		
Assignment code			To be paid by the insurance company				
Patient signatur	re Signature and stamp medical Healtho			entre	Signature and stamp of the Doctor		
Prescribed (Sectio	on Reserved For	6. Med The Presci	dicines	For Tl	Se he Pharmacist	ction Reserved :	
No: Dru	gs	Dosage	Quantity	Total	Cost		
1 ABJ	VCFU	11 1	11	121			
	<u>t:</u> The prescribing	Total am	ount:	121.0	0		

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 (%)	118.58
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	2.42
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist