Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center		al	
Matricule:			Date and Time:			
Nom:			Agreed healthcar	e netwo	rk:	
Carte ID:						
Full Name (first, middle, last):						
Age:			Prescribing Doctor fwe fwef wef	or / orien	tation:	
Marital Status :						
Gender :						
ledical Procedures:						
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost	
				<u> </u>		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : Iedical Procedures:	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : Iedical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Iedical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Code Designation (Medical Coefficient)	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Code Designation (Medical Coefficient Rate	

<u>Important:</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 enter	ice Medical		
<u>Important:</u> ⁻	The validity	y of this form cannot e	xceed 5 days	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	tails Of P	aram	edical Procedu	ıres:	
Date C	ode	le Designation (Medical acts)		Coefficie	cient Rate		Total Cost	
Important: The validity of this form cannot excee			xceed 5 days			Total amount:		
from the da	te of issue			To be	e paid	by the patient		
Assignment code				To be pa	aid by	id by the insurance company		
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor					
Prescribed (Section Reserved For			6. Me The Presc	Section Reserved ibing				
No:	Dru	ıgs	Dosage	Quantity	Total	Cost		
1	des	;	10	10	1000			
lmi	<u>Important:</u> The prescribing		Total an	nount: 1000.00				

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 (%)	200.00
		To be paid by MAADO	800.00
Signature and stamp Prescribing Doctor		Signa	ture and stamp Pharmacist