## **Medical Care Form**

Claim number: 3453

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:			
Nom:	Prashant 1997-10-28		Agreed healthcare network:			
Carte ID:	234					
Full Name (first, middle, last):	Prashant 1997-10-28					
Age:	25.8		Prescribing Doctor / orientation: sdf sdf fsd			
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: Prashar  Carte ID: 234  Full Name (first, middle, last):  Age: 25.8  Marital Status :  Gender : Male  Edical Procedures:  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Prashant 1997-10-28  Carte ID: 234  Full Name (first, middle, last): Age: 25.8  Marital Status: Gender: Male  dical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 1997-10-28  Agreed healthcare  Carte ID:  234  Full Name (first, middle, last):  Age:  25.8  Prescribing Docto sdf sdf fsd  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Prashant 1997-10-28  Agreed healthcare networ  Carte ID:  234  Full Name (first, middle, last):  Age:  Age:  25.8  Prescribing Doctor / orient sdf sdf fsd  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. Pati Policy		3. Infos Referer Center	nce Medical	
<u>lmporta</u> ı	<u>nt:</u> The vali	idity of this form cannot e	exceed 5 days	from the	Tota	al amount:
date of is	ssue				To be paid by t	the patient
Assignment code				To be paid by the insurance company		· I
			5. Det	ails Of Pa	ramedical Proced	ures:
Date	Code	Designation (Medical	Designation (Medical acts)		nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5		exceed 5 days		Total amount	:	
from the	date of iss	sue		To be	paid by the patient	t
Assignm	ent code			To be pai	d by the insurance company	
Patien	t signature	e Signature and stamp medical Healthcare centre Doctor				
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)				Section Reserved For The Pharmacist		
No: Drug	S		Dosage	Quantity	Total Cost	
PARACETAMOL/CODEINE TEVA 500 mg/30 mg, comprimé pelliculé		<sup>0</sup> mg, 1	1	1		
	I		Total ar	nount:	1.00	
	<u>ımportant</u>	: The prescribing		<u> </u>		

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 (%)	0.20
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.80
Sig	gnature and stamp Prescribing Doctor		ure and stamp Pharmacist