## **Medical Care Form**

Claim number:

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care			2. Patient Policy	3. Infos Reference Medical Center			
Primary	Matricule:			Date and Time:			
insured	Nom:	sourabh 2024-01-01		Agreed healthcare network:			
	Carte ID:	fff					
	Full Name (first, middle, last):	sourabh 2024-01-01					
Patient	Age:	0.2		Prescribing Doctor / orientation:			
	Marital Status :						
	Gender :	Male					
4. Details Of M	edical Procedures:						
Date	K OUG	Designation (Medical acts)		Coefficient	Rate	Total Cost	

<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	

Total amount: To be paid by the patient  To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  Goctor  6. Medicines The Prescribing For The Pharmacist  Section Reserved For The Pharmacist	Information & Access To Health Care				2. Patient Policy		3. Infos Reference Medical Center		
Assignment code  To be paid by the patient To be paid by the insurance company  5. Details Of Paramedical Procedures:  Date Code Designation (Medical acts) Coefficient Rate Total Cost  To be paid by the insurance company  Total amount: To be paid by the patient Rate Total Cost  Total amount: To be paid by the patient Rate Total Cost  To be paid by the patient Rate Total Cost  To be paid by the patient Rate Total Cost  To be paid by the patient Rate Rate Rate Rate Rate Rate Rate Rat									
Assignment code  To be paid by the insurance company  5. Details Of Paramedical Procedures:  Code Designation (Medical acts) Coefficient Rate Total Cost  Important: The validity of this form cannot exceed 5 days from the date of issue  To be paid by the patient  To be paid by the patient  To be paid by the insurance company  Patient signature Signature and stamp medical Healthcare centre Company  Frescribed (Section Reserved For The Pharmacist Section Reserved For The Pharmacist The Pharmacist Total amount:  To be paid by the patient Signature and stamp of the Doctor  Section Reserved For The Pharmacist The Pharmacist Total amount:  Total amount: 100.00	<u>lmportant</u>	<u>t:</u> The validit	y of this form cannot e	exceed 5 days t	from the		Tota	al amount:	
5. Details Of Paramedical Procedures:  Date Code Designation (Medical acts) Coefficient Rate Total Cost  Important: The validity of this form cannot exceed 5 days from the date of issue  To be paid by the patient  Assignment code  Patient signature  Signature and stamp medical Healthcare centre Company  6. Medicines The Prescribing  For The Pharmacist  Octor  Doctor  Dosage Quantity  Total amount:  Total amount:  Total amount:  Total amount:  To be paid by the insurance company  Signature and stamp of the Doctor  The Prescribing  Total amount:	date of iss	sue					To be paid by the patient		
Date Code Designation (Medical acts) Coefficient Rate Total Cost    Date   Code   Designation (Medical acts)   Coefficient   Rate   Total Cost	Assignme	nt code							
mportant: The validity of this form cannot exceed 5 days  To be paid by the patient  To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  Signature and stamp of the Doctor  Coctor  Coctor  Doctor  Doctor  Dosage Quantity Total Cost  1 10010  Total amount: 100.00				5. Det	ails Of Pa	ıramı	edical Procedu	ıres:	
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1 10010 Total amount: 100.00	Prescribed (Section Reserved For Doctor)			The	Section Reserved				
Total amount: 100.00	No:	Dri	ugs	Dosage	Quantity T	otal	Cost		
	1				1	0010			
				Total am	ount: 100.00				

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 (%)	20.00
		To be paid by MAADO	80.00
Signature and stamp Prescribing Doctor		Signa	ture and stamp Pharmacist