## **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<br>Policy | 3. Infos Reference Medical<br>Center           |      |               |  |
| Primary                                | Matricule:                          |                                       |                      | Date and Time:                                 |      |               |  |
| insured                                | Nom:                                | rohit 2024-01-03                      |                      | Agreed healthcare network:                     |      |               |  |
|  | Carte ID:                           | sdfsdf                                |                      |  |      |               |  |
|  | Full Name (first, middle,<br>last): | rohit 2024-01-03                      |                      |  |      |               |  |
| Patient                                | Age:                                | 0.2                                   |                      | Prescribing Doctor / orientation: efw efwef we |      |               |  |
|  | Marital Status :                    |                                       |                      |  |      |               |  |
|  | Gender :                            | Male                                  |                      |  |      |               |  |
| 4. Details Of M                        | edical Procedures:                  |                                       |                      |  |      |               |  |
| Date                                   | l one                               | Designation (Medical<br>acts)         |                      | Coefficient                                    | Rate | Total<br>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 |  |

| 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  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 Signature and stamp of the Doctor  6. Medicines The Prescribing  Prescribed (Section Reserved For The Pharmacist  | Information & Access To Health Care       |  |                   |              | 2. Patient<br>Policy |                  | . Infos Referen<br>enter | ce Medical             |  |
|--|---|--|-------------------|--------------|----------------------|------------------|--------------------------|------------------------|--|
| Assignment code  To be paid by the insurance company  5. Details Of Paramedical Procedures:  Date Code Designation (Medical acts) Coefficient Rate Total Cost  In the validity of this form cannot exceed 5 days from the date of issue  To be paid by the insurance company  To be paid by the patient  To be paid by the insurance company  Form the date of issue  For the patient signature and stamp medical Healthcare centre Signature and stamp of the Doctor  Prescribed (Section Reserved For The Pharmacist  To be paid to the insurance company  Signature and stamp of the Doctor  For The Pharmacist  Total amount: Total Cost  The Prescribing For The Pharmacist  Total amount: Total Cost  Total amount: Total Cost  |   |  |                   |              |                      |                  |                          |                        |  |
| 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  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 insurance company  Patient signature Signature and stamp medical Healthcare centre Doctor  Frescribed (Section Reserved For The Pharmacist For The Pharmacist For The Pharmacist In the Prescribing For The Pharmacist In th | <u>Important</u>                          | exceed 5 days  | d 5 days from the |              | Total 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 insurance company  Patient signature Signature and stamp medical Healthcare centre Company  Prescribed (Section Reserved For The Pharmacist  To bright Pharmacist  Section Reserved For The Pharmacist  Doctor  Doctor  Dosage Quantity Total Cost  In hello In   | date of iss                               | date of issue  |                   |              |                      |                  | To be paid by t          | be paid by the patient |  |
| Date Code Designation (Medical acts) Coefficient Rate Total Cost    Coefficient Rate   Total Cost  | Assignme                                  | nt code  |                   |              |                      |                  |                          |                        |  |
| To be paid by the patient To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  Prescribed (Section Reserved For The Prescribing  To Medicines The Prescribing  The Pharmacist  To be paid by the insurance company  Signature and stamp of the Doctor  The Prescribing  For The Pharmacist  To be paid by the patient  To be paid  |   |  |                   | 5. Det       | ails Of P            | aram             | edical Procedu           | ıres:                  |  |
| To be paid by the patient  To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  6. Medicines The Prescribed (Section Reserved For The Prescribing  Doctor)  Doctor  Doctor  Doctor  Dosage Quantity Total Cost Total amount: 100.00  | Date                                      | Date Code Designation (Medical acts)                     |                   | acts)        | Coefficie            | Coefficient Rate |                          | Total Cost             |  |
| To be paid by the patient  To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  6. Medicines The Prescribed (Section Reserved For The Prescribing  Doctor)  Doctor  Doctor  Doctor  Dosage Quantity Total Cost Total amount: 100.00  |   |  |                   |              |                      |                  |                          |                        |  |
| To be paid by the patient  To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  6. Medicines The Prescribed (Section Reserved For The Prescribing  Doctor)  Doctor  Doctor  Doctor  Dosage Quantity Total Cost Total amount: 100.00  |   |  |                   |              |                      |                  |                          |                        |  |
| To be paid by the patient  To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  6. Medicines The Prescribed (Section Reserved For The Prescribing  Doctor)  Doctor  Doctor  Doctor  Dosage Quantity Total Cost Total amount: 100.00  |   |  |                   |              |                      |                  |                          |                        |  |
| To be paid by the patient  To be paid by the insurance company  Patient signature  Signature and stamp medical Healthcare centre  6. Medicines The Prescribed (Section Reserved For The Prescribing  Doctor)  Doctor  Doctor  Doctor  Dosage Quantity Total Cost  hello 10 10 100  Total amount: 100.00  | _   | <u>Important:</u> The validity of this form cannot excee |                   |              |                      |                  | Total amount:            |                        |  |
| Patient signature Signature and stamp medical Healthcare centre Signature and stamp of the Doctor  6. Medicines The Prescribed (Section Reserved For The Prescribing  Doctor)  Doctor  Doctor  Doctor  Doctor  Doctor  Total amount: 100.00  | from the o                                | date of issu   | e                 |              | To be                | paid             | l by the patient         |                        |  |
| Prescribed (Section Reserved For  The Prescribing  Doctor  Doctor  Doctor  Section Reserved For The Pharmacist  Doctor  Doctor  Total amount: 100.00   | Assignme                                  | nt code  |                   |              | To be pa             | · · · · · ·      |                          |                        |  |
| Prescribed (Section Reserved For The Pharmacist  No: Drugs Dosage Quantity Total Cost  1 hello 10 10 100  Total amount: 100.00   | Patient signature Signature and stamp med |  |                   | medical Heal | ealthcare centre I - |                  |                          | l stamp of the         |  |
| 1 hello 10 100  Total amount: 100.00   | Prescribed (Section Reserved For  Doctor) |  |                   | The          | Section Reserve      |                  |                          |                        |  |
| Total amount: 100.00   | No:                                       | Di   | rugs              | Dosage       | Quantity             | Total            | Cost                     |                        |  |
|  | 1   | he   | ello              | 10           | 10                   | 100              |                          |                        |  |
|  |   |  | Total am          | ount: 100.00 |                      |                  |                          |                        |  |

| Prescrik<br>each<br>Doctor)            | practitioner will<br>ped (Section Reserved For<br>indicate the duration of treatment for<br>drug, | 6. Medicines The Prescribing     | Section Reserved<br>For The Pharmacist |
|--|---|----------------------------------|--|
| and                                    | this form is valid only for one pharmacy  | To be paid by<br>the patient (%) | 20.00                                  |
|  |   | To be paid by<br>MAADO           | 80.00                                  |
| Signature and stamp Prescribing Doctor |   | Signa                            | ture and stamp Pharmacist              |