Medical Care Form

Claim number:werfw34

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care		2. Patient	3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:	Suyesh 15151 2023-09-02		Agreed healthcare network:			
Carte ID:	22					
Full Name (first, middle, last):	Suyesh 15151 2023-09-02					
Age:	0.3		Prescribing Doctor / orientation:			
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: Carte ID: 22 Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male Addical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Male dical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Center Matricule: Date and Time: Nom: Suyesh 15151 2023-09-02 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orient 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. Pat Policy		3. Infos Referer Center	nce Medical		
Important: The validity of this form cannot exceed			exceed 5 days	from the	Tota	al amount:	
date of issue					To be paid by t	To be paid by the patient	
Assignmeı	Assignment code			To be paid by insurance compa			
			5. Det	ails Of Paı	ramedical Procedo	ures:	
Date	Code Designation (Medical acts)		l acts)	Coefficien	nt Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days		Total amount		
from the o	date of iss	sue		To be բ	paid by the patient	t	
Assignment code				To be paid by the insurance company			
Patient	Patient signature Signature and stamp medical Healthcare centre Doctor			d stamp of the			
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)				ection Reserved t			
No:		Drugs	Dosage (QuantityTo	otal Cost		
1				90	00		
Important: The prescribing		Total am	ount: 90	00.00			

Prescrib 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 (%)	594.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	306.00
Sigr	nature and stamp Prescribing Doctor	Signa	بر ture and stamp Pharmacist