## **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 Center	e Medica	al
Matricule:			Date and Time:		
Nom:	john 2002-03-05		Agreed healthcare network:		
Carte ID:	42858				
Full Name (first, middle, last):	john 2002-03-05				
Age:	22.0		Prescribing Doctor / orientation: fsd sdf sdf		
Marital Status :					
Gender :	Male				
edical Procedures:					
LOGE		ation (Medical	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:  john 20  Carte ID:  42858  Full Name (first, middle, last):  Age:  22.0  Marital Status:  Gender:  Male	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  john 2002-03-05  Carte ID:  42858  Full Name (first, middle, last):  Age: 22.0  Marital Status:  Gender:  Male  dical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: john 2002-03-05 Agreed healthcare  Carte ID: 42858  Full Name (first, middle, last):  Age: 22.0 Prescribing Docto fsd sdf sdf  Marital Status:  Gender: Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  john 2002-03-05  Agreed healthcare networ  Carte ID:  42858  Full Name (first, middle, last):  Age:  Age:  22.0  Prescribing Doctor / orient fsd sdf sdf  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Total and Important: The validity of this form cannot exceed 5 days from the date of issue  To be paid by the paid							
Important: The validity of this form cannot exceed 5 days from the date of issue							
	mount:						
	To be paid by the patient						
Assignment code insurance con							
5. Details Of Paramedical Procedures:							
Date Code Designation (Medical acts) Coefficient Rate Tota	tal Cost						
Total amount: Important: The validity of this form cannot exceed 5 days							
from the date of issue  To be paid by the patient							
Assignment code To be paid by the insurance company							
Patient signature Signature and stamp medical Healthcare centre Doctor	Signature and stamp of the Doctor						
Prescribed (Section Reserved For  The Prescribing  Doctor)  6. Medicines  Section  For The Pharmacist	Section Reserved						
No: Drugs Dosage Quantity Total Cost							
1 x-ray 10 10 100							
Total amount: 100.00  Important: The prescribing							

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 (%)	30.00
		To be paid by MAADO	70.00
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist	