Medical Care Form

Claim number:

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire	bligatoire			
Information & Access To Health Care			2. Patient Policy	3. Infos Reference Medical Centei			
Primary	Matricule:			Date and Time:			
insured	Nom:	Pranali 20	00-10-11	Agreed healthcare network:			
Patient	Carte ID:						
	Full Name (first, middle, last):	Pranali 20	00-10-11				
	Age:	23.3		Prescribing Doctor / orientation: mentor patel prashant			
	Marital Status :						
	Gender :	Female					
4. Details Of M	ledical Procedures:						
Date	Code	Designation (Medical acts)		Coefficient	Rate	Total Cost	

<u>lmportant:</u> The validity of this form canno	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 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 Doctor 6. Medicines The Prescribed (Section Reserved For The Pharmacist	Information & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center			
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Total amount: 100.00	No:	Drugs			Dosage	Quantity	Total	Cost	
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				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 (%)	100.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Signature and stamp Prescribing Doctor		Signat	ture and stamp Pharmacist