Medical Care Form

Claim number: 65767

1. Health Insurance System Information		Filling Instructions					
SAM code:			Write legibly				
SAM:			D obligatoire				
Access To Health Care			3. Infos Reference Medical C		l Center		
Matricule:			Date and Time:				
Nom:	dhiraj 2001-10-10		Agreed healthcare network:				
Carte ID:	32332						
Full Name (first, middle, last):	dhiraj 20	001-10-10					
Age:	22.3		Prescribing Doctor / orientation: yuytu yujyi uyiuyi				
Marital Status :							
Gender :	Male						
ledical Procedures:							
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : Iedical Procedures:	Access To Health Care Matricule: Nom: Carte ID: Substitute: Full Name (first, middle, last): Age: Age: Carte ID: Age: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Marital Status: Gender: Male Male Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: dhiraj 2001-10-10 Agreed healthcare Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Prescribing Doctor yuytu yujyi uyiuyi Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Agreed healthcare network Carte ID: 32332 Full Name (first, middle, last): Age: 22.3 Prescribing Doctor / orients yuytu yujyi uyiuyi Marital Status: Gender: Male Male Designation (Medical Coefficient Rate		

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

Informati	formation & Access To Health Care			2. Patient Policy		3. I	3. Infos Reference Medical Center		
<u>lmportant</u>	: The validit	y of this form cannot (exceed	5 days	from the		Tota	l amount:	
date of iss	ue					7	o be paid by th	ne patient	
Assignment code					To be paid by the insurance company				
				5. Det	ails Of P	arame	edical Procedu	ıres:	
Date	e Code Designation (Medical acts)				Coefficie	ent	nt Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed 5			5 days			Total amount:			
from the o	late of issue				To be	paid	by the patient		
Assignment code			To be p	paid by the insurance company					
Patient	signature	Signature and stamp	thcare cα	entre	Signature and stamp of the Doctor				
Prescribed (Section Reserved For The			6. Med The Presci	dicines ribing	For Th	Section Reserved For The Pharmacist			
No:	Drugs		[Dosage (Quantity	Total	Cost		
1	taaaaaaaa	aa	C) ()	0			
Important: The prescribing			Total am	ount:	0.00				

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 (%)	0.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist