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 Medical Center			
Matricule:	john 2002-03-05		Date and Time:			
Nom:			Agreed healthcare network:			
Carte ID:	42858					
Full Name (first, middle, last):	john 2002-03-05					
Age:	22.0		Prescribing Doctor / orientation: john doe			
Marital Status :						
Gender :	Male					
4. Details Of Medical 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: john 20 Carte ID: 42858 Full Name (first, middle, last): Age: 22.0 Marital Status: Gender: Male edical Procedures: Designa	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 john doe 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: Age: 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. Patient Policy		Infos Referen enter	ce Medical		
<u>Important</u>	:: The validit	ty of this form cannot e	exceed 5 days 1	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by th insurance compar				
			5. Det	ails Of Pa	arame	edical Procedu	ıres:	
Date	Code Designation (Medical acts)		acts)	Coefficie	ficient Rate		Total Cost	
Important: The validity of this form cannot exceed			exceed 5 days			Total amount:		
from the o	date of issue			To be	paid	by the patient		
Assignment code				To be pa	e paid by the insurance company			
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The				dicines	Section Reserved			
No:	Dr	ugs	Dosage	Quantity	Total (Cost		
1					100			
			Total am	ount: 1	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
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist