Medical Care Form

Claim number:23e23e

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care			2. Patient Policy	3. Infos Reference	Medical	Center	
Primary	Matricule:			Date and Time:			
insured	Nom:	Suyesh 15151 2023-09-02		Agreed healthcare network:			
Patient	Carte ID:	22					
	Full Name (first, middle, last):	Suyesh 1	5151 2023-09-02				
	Age:	0.3		Prescribing Doctor / orientation: Henry M Mellwood			
	Marital Status :						
	Gender :	Male					
4. Details Of M	ledical Procedures:						
Date	K ode	Designation (Medical acts)		Coefficient	Rate	Total Cost	

<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	

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 insurance company Patient signature Signature and stamp medical Healthcare centre Frescribed (Section Reserved For The Prescribing Section Reserved For The Pharmacist	Information & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center		
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Total amount: 365.00	No:	Dr	ugs	Dosage(QuantityT	otal (Cost	
	1				3	65		
				Total am	ount: 3	65.00		

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 (%)	240.90	
		To be paid by MAADO	124.10	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		