Medical Care Form

Claim number :23r23r

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 insured	Matricule:		Date and Time:
	Nom:	Prashant 2000-10-10	Agreed healthcare network:
Patient	Carte ID:		
	Full Name (first, middle, last):	Prashant 2000-10-10	
	Age:	23.3	Prescribing Doctor / orientation: 23r 23r 23r
	Marital Status :		
	Gender :	Male	

4. Details Of Medical 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		Total amount:	
		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Information & Access To Health Care	2. Patient Policy	3. Infos Reference Medical Center

Important: 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	

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		Total amount:	
		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Patient signature	Signature and stamp medical Healthcare centre	Signature and stamp of the Doctor

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Prescribed (Section Reserved For Doctor)	6. Medicines The Prescribing	Section Reserved For The Pharmacist

No:	Drugs	Dosage	Quantity	Total Cost
1	perindopril tosilate teva 10 mg, comprimé pelliculé	20	20	200

Prescribed (Section Reserved For Doctor)		6. Medicines The Prescribing		Section Reserved For The Pharmacist
2	aripiprazole sandoz 10 mg, comprimé orodispersible	10	10	100
Important: The prescribing practitioner will indicate the duration of treatment for each drug, this form is valid only for one pharmacy and its validity cannot exceed 72 hours after delivery		Total amount:		300.00
		To be paid by the patient (%)		0.00
		To be paid by MAADO		300.00
Signature and stamp Prescribing Doctor		_____ Signature and stamp Pharmacist		