Medical Care Form

Claim number:456

1. Health Insurance System Information		Filling Instructions			
SAM code:		Write legibly			
SAM:		ID obligatoire			
Information & Access To Health Care		2. Patient	3. Infos Reference Medical Center		
Matricule:			Date and Time:		
Nom:			Agreed healthcare network:		
Carte ID:	569161				
Full Name (first, middle, last):	Lindsay Laura 1973-02-12				
Age:	50.7		Prescribing Doctor / orientation: rf34f 34f 34f		
Marital Status :					
Gender :	Female				
edical Procedures:					
Lone	Designation (Medical acts)		Coefficient	Rate	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: Carte ID: Full Name (first, middle, last): Age: Age: Gender: Female Edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Lindsay Laura 1973-02-12 Carte ID: Full Name (first, middle, last): Age: 50.7 Marital Status: Gender: Female Edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Lindsay Laura 1973-02-12 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: So.7 Prescribing Doctorf34f 34f 34f Marital Status: Gender: Female Posignation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Center Matricule: Date and Time: Nom: Lindsay Laura 1973-02-12 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Age: 50.7 Prescribing Doctor / orient rf34f 34f 34f Marital Status: Gender: Female Pesignation (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. Pati Policy		3. Infos Referer Center	nce Medical	
<u>lmporta</u>	nt: The vali	idity of this form cannot e	exceed 5 days	from the	Tota	al amount:
date of i	ssue				To be paid by t	he patient
Assignment code				To be paid by the insurance company		
	5. Details Of Paramedical Procedures:				ures:	
Date	Code	Designation (Medical	Designation (Medical acts)		it Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5 d		exceed 5 days		Total amount		
from the	date of is	sue		To be μ	paid by the patient	
Assignm	ent code			To be paid	d by the insurance company	
Patien	t signature	e Signature and stamp	Signature and stamp medical Healthcare centre Doctor			d stamp of the
O. Medicines Prescribed (Section Reserved For The Prescribing Doctor) 6. Medicines Section Reserved For The Pharmacist						
No: Drug	[S		Dosage	QuantityT	otal Cost	
-	prazole sa ispersible	ndoz 10 mg, comprimé	2	2 4		
	l	u Tha muaganihin -	Total an	nount: 4	.00	
	<u>ımportant</u>	: 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 (%)	3.92
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.08
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist