Medical Care Form

Claim number:555555tttttt

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire				
Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:	Laura M 20	larhysa 1978-01-	Agreed healthcare network:				
Carte ID:	594565						
Full Name (first, middle, last):	Laura M 20	larhysa 1978-01-					
Age:	45.8		Prescribing Doctor / orientation: 7777 7777 777				
Marital Status :							
Gender :	Female						
edical 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 : edical Procedures:	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: 45.8 Marital Status: Gender: Female edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Marital Status: Gender: Female edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, Laura Marhysa 1978-01-20 Age: 45.8 Prescribing Docto 7777 7777 7777 Marital Status: Gender: Female Code Designation (Medical Coefficient	Write legibly D obligatoire		

<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		3. Infos Refei Center	rence Medical			
<u>Importar</u>	nt: The v	alidity	y of this form cannot e	exceed 5 days 1	from the	Т	otal amount:	
date of issue						To be paid by the patient		
Assignment code					To be paid by the insurance company			
5. Details Of Para				ails Of Paraı	medical Proce	edures:		
Date	Code		Designation (Medical a	acts)	Coefficient	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5 d			exceed 5 days		Total amou	nt:		
from the date of issue			To be pa	id by the patio	ent			
Assignment code				To be paid by the insurance company				
Patien	Patient signature Signature and stamp medical Healthcare centre Doctor			and stamp of the				
,								

Pres Doct	cribed (Section Reserved For tor)	The	edicines	Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
1	gabapentine ranbaxy 400 mg, gélule	2020	20	0

Prescribed (Section Reserved For Doctor)			edicines	Section Reserved For The Pharmacist	
2	gabapentine ranbaxy 400 mg, gélule	2020	20	0	
	Important: The prescribing practitioner will indicate the duration of treatment for	Total ar	mount:	0.00	
each and	drug, 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	
	Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		