## **Medical Care Form**

Claim number:7567

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		al	
Matricule:			Date and Time:			
Nom:	prashant kumar 1998-10- 28		Agreed healthcare network:			
Carte ID:	574372					
Full Name (first, middle, last):	prashant kumar 1998-10- 28					
Age:	24.8		Prescribing Doctor / orientation: t5 t5 t5			
Marital Status :						
Gender :	Male					
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, prashandlast):  Age:  Age:  Age:  Gender:  Male  Male	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Age:  24.8  Marital Status:  Gender:  Male  Male  edical Procedures:	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Age:  24.8  Marital Status:  Gender:  Male  Write legibly  ID obligatoire  3. Infos Reference Center  Agreed healthcare  Policy  Patient  Policy  Prescribing Doctore  15 t5 t5  Male	Write legibly  ID obligatoire  2. Patient Policy  Matricule: Date and Time:  Nom:  Prashant kumar 1998-10-28  Carte ID: Full Name (first, middle, last): Age: 24.8  Prescribing Doctor / orient to 15 to 15  Marital Status:  Gender: Male  Mrite legibly  ID obligatoire  3. Infos Reference Medica Center  Agreed healthcare networe  Agreed healthcare networe  Agreed healthcare networe  Prescribing Doctor / orient to 15 to 15 to 15  Marital Status:  Gender: Male	

<u>Important:</u> 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	

Informati	ormation & Access To Health Care		2. Pati Policy	ient		Infos Referen enter	ce Medical
<u>Important</u>	<u>t:</u> The validit	y of this form cannot (	exceed 5 days 1	from the		Tota	al amount:
date of iss	sue				7	Γo be paid by t	he patient
Assignment code					To be paid by the insurance company		
			5. Det	ails Of Pa	ıramı	edical Procedu	ıres:
Date	Code	ode Designation (Medical acts)		Coefficie	nt	Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5 c		exceed 5 days			Total amount:		
from the (	date of issue	2		To be	paid	by the patient	
Assignment code			To be pa	be paid by the insurance company			
Patient	signature	e Signature and stamp medical Healthcare centre Doctor			l stamp of the		
6. Me Prescribed (Section Reserved For The Presc Doctor)			dicines	or Th	Section Reserved or The Pharmacist		
No:	Dru	ugs	Dosage	QuantityT	otal	Cost	
Important: The prescribing practitioner will		Total am	Total amount: null				
			To be paid by the patient (%)		I		

indicate the duration of treatment for Paebcribed (Section Reserved For drug, Doctor)	The Prescribing	Section Reserved For The Pharmacist
and  its  validity cannot exceed 72 hours after	To be paid by	null
delivery  Signature and stamp Prescribing Doctor		
Signature and Stamp Prescribing Doctor	Signa	ture and stamp Pharmacist