Medical Care Form Claim number:

345

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:	Dhanashree 23423 2023- 05-09		Agreed healthcare network:				
Carte ID:	: 234234						
Full Name (first, middle, last):	Dhanash	nree 23423 2023- 05-09					
Patient Age:		0.3	Prescribing Doctor / orientation: 6456 456 456				
Marital Status :							
Gender :		Female					
4. Details Of Medical Procedures:							
Code	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Information SAM code: SAM: Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : Iedical Procedures:	Information SAM code: SAM: Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : Iedical Procedures:	Information SAM code: Write legibly SAM: ID obligatoire 2. Patient Policy Matricule: Nom: Dhanashree 23423 2023- 05-09 Carte ID: 234234 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Female Iedical Procedures: Code Designation (Medical	Information SAM code: Write legibly SAM: ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhanashree 23423 2023- 05-09 Carte ID: 234234 Full Name (first, middle, last): Age: O.3 Prescribing Doctorientation: 6456 Marital Status: Gender: Female Designation (Medical Coefficient	Information SAM code: Write legibly SAM: ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhanashree 23423 2023- 05-09 Carte ID: 234234 Full Name (first, middle, last): Age: O.3 Prescribing Doctor / orientation: 6456 456 45 Marital Status: Gender: Female Designation (Medical Coefficient Rate		

<u>Important:</u> The validity of this form ca	Total amount:		
the date of issu	To be paid by the patient		
Assignment code		To be paid by the insurance company	

Inform	rmation & Access To Health Care		2. Patient Policy			. Infos Refere enter	nce Medi	cal		
Important: The validity of this form cannot exceed 5 day					days fro	n	Tota	l amount:		
	the date of issue						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)			Coeffic	ient	ent Rate To		t
<u>Important:</u> The validity of this form cannot exceed 5					T	Total amount:				
days from the date of issue To be pa				aid b	y the patient					
Assig	ssignment cone						e paid by the nce company			
Patie	Patient signature Signature and stamp medical Healthcare centre					re	Signature and stamp of the Doctor			
6. Medicines Prescribed (Section Reserved For The Reserved For The Pharmacist Prescribing Doctor)										
No:	Drugs D			Dosage	Quantity	Tota	tal Cost			
1	LYRICA 300 mg, gélule		10	1	1					
	<u>Important:</u> The prescribing		Total a	mount:	1.00					

practitioner will Medicines Prescribed (Section Reserved For indicate the duration of treatment for each Prescribing Doctor) drug,	6. The	Section Reserved For The Pharmacist
this form is valid only for one pharmacy and	To be paid by the patient (%)	0.20
its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.80
Signature and stamp Prescribing Doctor	Signatu	ire and stamp Pharmacist