Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
		ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center		al	
Matricule:			Date and Time:			
Nom:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto fwef wef wef	r / orien	tation:	
Marital Status :						
Gender :						
4. Details Of Medical Procedures:						
l one	Designation (Medical acts)		Coefficient	Rate	Total Cost	
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender:	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Designation (Medical Coefficient Rate	

<u>Important:</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		. Infos Referen enter	ice Medical		
<u>Important</u>	<u>::</u> The validit	y of this form cannot e	exceed 5 days	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by th insurance compar				
			5. De	tails Of P	aram	edical Procedu	ıres:	
Date	Code Designation (Medical acts)		acts)	Coefficie	ent	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days			Total amount:		
from the o	date of issue			To be	e paid	by the patient		
Assignment code				To be p	paid by the insurance company			
Patient	signature	Signature and stamp medical Health			Signature and stamp of the Doctor			
Prescribe	d (Section R	eserved For	The	dicines	For T	Se he Pharmacist	ction Reserved :	
No:	Drugs		Dosage	Quantity	Total	Cost		
1	imaging	1		10	100			
			Total ar	nount:	100.0	00		
Important: The prescribing								

Prescrib 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 (%)	100.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Sigı	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist