Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions					
SAM code:		Write legibly					
SAM:			ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center		al		
Matricule:			Date and Time:				
Nom:	Dhiraj G. 2000-06-18		Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Dhiraj G. 2000-06-18						
Age:	23.4		Prescribing Doctor / orientation:				
Marital Status :							
Gender :	Male						
edical 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: edical Procedures:	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Code Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare netword Carte ID: Full Name (first, middle, last): Age: 2. Patient Policy Date and Time: Agreed healthcare netword Agreed healthcare netword Prescribing Doctor / orient Marital Status: Gender: Male 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		fos Referen	ce Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	l amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	ramedi	ical Procedu	res:	
Date	Code	Designation (Medical acts)		Coefficie	nt Ra	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed 5			exceed 5 days		То	tal amount:		
from the o	date of issue			To be	paid by	the patient		
Assignment code				To be pa	paid by the insurance company			
Patient signature Signature and stamp medical Heal			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The			dicines ribing	Section Reserved For The Pharmacist				
No:	Dr	ugs	Dosage	Quantity T	otal Co	st		
1				4	668			
_			Total am	ount: n	ull			
Important: The prescribing			<u> </u>					

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 (%)	null
		To be paid by MAADO	null
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist