Medical Care Form

Claim number:r34r

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:	Prashant 1997-10-28		Agreed healthcare network:			
Carte ID:	234					
Full Name (first, middle, last):	Prashant 1997-10-28					
Age:	25.8		Prescribing Doctor / orientation: 34r 34r 34r			
Marital Status :						
Gender :	Male					
edical Procedures:						
LOGE	Designation (Medical acts)		Coefficient	IRate	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: Prashar Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status : Gender : Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Marital Status: Gender: Male dical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1997-10-28 Agreed healthcare Carte ID: 234 Full Name (first, middle, last): Age: 25.8 Prescribing Docto 34r 34r 34r Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 1997-10-28 Agreed healthcare networ Carte ID: 234 Full Name (first, middle, last): Age: Age: 25.8 Prescribing Doctor / orient 34r 34r 34r Marital Status: Gender: Male Policy 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. Pati Policy		3. Infos Referer Center	nce Medical	
<u>lmporta</u> ı	<u>nt:</u> The vali	idity of this form cannot e	exceed 5 days	from the	Tot	al amount:
date of is	ssue				To be paid by t	the patient
Assignment code				To be paid by the insurance company		· I
	5. Details Of Paramedical Procedures:					ures:
Date	Code	Designation (Medical	Designation (Medical acts)		nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5		exceed 5 days		Total amount	:	
from the	date of is	sue		To be	paid by the patien	t
Assignm	ent code			To be pa	id by the insurance company	
Patien	t signature	Signature and stamp medical Healthcare centre Doctor				
Prescrib Doctor)	ed (Sectio	n Reserved For	6. Med The Prescr	dicines	S For The Pharmaci	ection Reserved st
No: Drug	S		Dosage	Quantity	Total Cost	
PARACETAMOL/CODEINE TEVA 500 mg/30 mg, comprimé pelliculé		0 mg, 2	2	4		
	lman autour	The prescribing	Total ar	nount:	4.00	
	<u>ımportant</u>	: The prescribing				

Prescril each Doctor)	practitioner will bed (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 (%)	0.80
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	3.20
Sig	gnature and stamp Prescribing Doctor		ure and stamp Pharmacist