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 | | | | | |
| Matricule: | | | Date and Time: | | | | | |
| Nom: | Pranali | 2000-10-11 | Agreed healthcare network: | | | | | |
| Carte ID: | | | | | | | | |
| Full Name (first, middle, last): | Pranali | 2000-10-11 | | | | | | |
| Age: | 23.3 | | Prescribing Doctor / orientation: dhiraj gurve | | | | | |
| Marital Status : | | | | | | | | |
| Gender : | Female | | | | | | | |
| 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: Pranali Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Female edical Procedures: Designation | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Pranali 2000-10-11 Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Female edical Procedures: Code Designation (Medical | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Pranali 2000-10-11 Agreed healthcar Carte ID: Full Name (first, middle, last): Age: Age: 23.3 Prescribing Doctor dhiraj gurve Marital Status: Gender: Female Designation (Medical Coefficient | Write legibly D obligatoire | | | |

| <u>lmportant:</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 | | | 3. Infos Referen Center | ice Medical | | | |
|---|--------------------------------------|--|----------------------|-----------------------------------|-------------------------------------|----------------------------|-------------------------------------|---------------------------|------------|--|
| | | | | | | | | | | |
| Important: The validity of this form cannot excee | | | | xceed 5 day | /s 1 | from the | | Tota | al amount: | |
| date of issue | | | | | | | | To be paid by the patient | | |
| Assignment code | | | | | | | To be paid by the insurance company | | | |
| 5. Details Of Paramedical Procedures: | | | | | | ıres: | | | | |
| Date | Date Code Designation (Medical acts) | | acts) | | Coefficient | | Rate | Total Cost | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| <u>Important:</u> The validity of this form cannot exceed | | | xceed 5 day | /S | | | Total amount | | | |
| from the date of issue | | | | | To be | e paid | d by the patient | | | |
| Assignment code | | | | | To be paid by the insurance company | | | | | |
| Patient signature Signature and stamp medical He | | | eal | Signature and stamp of the Doctor | | | | | | |
| Prescribed (Section Reserved For The | | | | | Section Reserved For The Pharmacist | | | | | |
| No: | Drugs Dosag | | еC | Quantity | Tota | al Cost | | | | |
| 1 | | | | | | | 256 | | | |
| <u>lr</u> | Important: The prescribing | | Total | am | nount: 256.00 | | | | | |

| Prescrik 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 (%) | 256.00 |
| | 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 |