## **Medical Care Form**

Claim number:qaqa

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:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto qa qa qa	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:  Age:  Marital Status:  Gender:  Designation (Medical Coefficient Rate	

<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		nfos Referen ter	ce Medical		
<u>Important:</u> <sup>-</sup>	The validity	y 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. Deta	ails Of Pa	ramed	ical Procedu	res:	
Date C	Code Designation (Medical acts)		acts)	Coefficie	nt R	Rate Total Cost		
Important: The validity of this form cannot exceed			xceed 5 days		To	otal amount:		
from the da	ite of issue			To be	paid by	/ the patient		
Assignment code				To be pa	aid by the insurance company			
Patient signature Signature and stamp medical Hea				Signature and stamp of the Doctor				
Prescribed (Section Reserved For The				licines ribing	Section Reserved For The Pharmacist			
No:	Dru	ıgs	DosageC	Quantity T	otal Co	st		
1	gfjh	1	1 1	1				
Important: The prescribing		Total am	ount: 1	.00				

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 (%)	0.40
		To be paid by MAADO	0.60
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist