Medical Care Form

Claim number:34r34r

SAM: ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: Patient Age: O.3 Prescribing Doctor / orientation: Marital Status: Gender: Male 4. Details Of Medical Procedures: Date and Time: Suyesh 15151 2023-09-02 Agreed healthcare network: Patient Age: O.3 Prescribing Doctor / orientation: Age: Code Designation (Medical Coefficient Rate Total	1. Health Insurance System Information			Filling Instructions			
Primary insured Matricule: Date and Time:	SAM code:			Write legibly			
Information & Access To Health Care Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Doctor / orientation: Marital Status : Gender : Male A. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total	SAM:			ID obligatoire			
Primary insured Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orientation: Marital Status: Gender: Male 4. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total	Information & Access To Health Care		2. Patient				
Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orientation: Marital Status : Gender : Male 4. Details Of Medical Procedures: Date Code Designation (Medical Coefficient Rate Total		Matricule:			Date and Time:		
Patient		Nom:			Agreed healthcare network:		
Patient Age: 0.3 Prescribing Doctor / orientation: Marital Status : Gender : Male 4. Details Of Medical Procedures: Date Code Designation (Medical Coefficient Rate Total		Carte ID:	22				
Marital Status : Gender : Male 4. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total			Suyesh 15151 2023-09-02				
Gender: Male 4. Details Of Medical Procedures: Date Code Designation (Medical Coefficient Rate Total	Patient	Age:	0.3		Prescribing Doctor / orientation:		
4. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total		Marital Status :					
Designation (Medical Coefficient Rate Total		Gender :	Male				
iDate Kode i – Koetticient ikate i	4. Details Of M	edical Procedures:					
acts)	Date	l ode	Designation (Medical acts)		Coefficient	Rate	Total Cost

<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. Pati Policy		3. Infos Reference Medical Center		
Important: The validity of this form cannot excee			exceed 5 days	from the	Tota	al amount:	
date of iss	date of issue				To be paid by t	To be paid by the patient	
Assignmeı	nt code					To be paid by the insurance company	
			5. Det	ails Of Pai	ramedical Procedu	ures:	
Date	Code	Designation (Medica	l acts)	Coefficier	nt Rate	Total Cost	
<u>Important:</u> The validity of this form cannot excee			exceed 5 days		Total amount		
from the o	date of is:	sue 		To be ¡	paid by the patient		
Assignment code				To be pai	To be paid by the insurance company		
Patient signature Signature and stamp me			np medical Heal	thcare cer	Signature and Doctor	d stamp of the	
Prescribed (Section Reserved For Doctor)			The	Medicines e e escribing For The Pharmacist			
No:		Drugs	Dosage (QuantityTo	otal Cost		
1				4:	50		
<u>Important:</u> The prescribing		Total am	nount: 450.00				

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 (%)	297.00	
		To be paid by MAADO	153.00	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		