

Medical Care Form


Claim number :

| | | | | | |
|--|----------------------------------|----------------------------|---|------|-----------------------------------|
| 1. Health Insurance System Information | | | Filling Instructions | | |
| SAM code: | | | Write legibly | | |
| SAM: | | | ID obligatoire | | |
| Information & Access To Health Care | | | 2. Patient Policy | | 3. Infos Reference Medical Center |
| Primary insured | Matricule: | | Date and Time: | | |
| | Nom: | Prashant 2000-10-10 | Agreed healthcare network: | | |
| Patient | Carte ID: | | | | |
| | Full Name (first, middle, last): | Prashant 2000-10-10 | | | |
| | Age: | 23.3 | Prescribing Doctor / orientation: dfwqe fwef wef | | |
| | Marital Status : | | | | |
| | Gender : | Male | | | |
| 4. Details Of Medical Procedures: | | | | | |
| Date | Code | Designation (Medical acts) | Coefficient | Rate | Total Cost |
| | | | | | |
| | | | | | |

| | | | |
|---|---------------------------|-------------------------------------|--|
| <u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue | Total amount: | | |
| | 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 Reference Medical Center | |
| | | | | | | |
| Important: The validity of this form cannot exceed 5 days from the date of issue | | | Total amount: | | | |
| | | | To be paid by the patient | | | |
| Assignment code | | | To be paid by the insurance company | | | |
| 5. Details Of Paramedical Procedures: | | | | | | |
| Date | Code | Designation (Medical acts) | Coefficient | Rate | Total Cost | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Important: The validity of this form cannot exceed 5 days from the date of issue | | | Total amount: | | | |
| | | | To be paid by the patient | | | |
| Assignment code | | | To be paid by the insurance company | | | |
| Patient signature | | Signature and stamp medical Healthcare centre | | Signature and stamp of the Doctor | | |

| | | | | | |
|---|--|--------|-------------------------------------|------------|--|
| 6. Medicines Prescribed (Section Reserved For The Doctor) | | | Section Reserved For The Pharmacist | | |
| No: | Drugs | Dosage | Quantity | Total Cost | |
| 1 | aripiprazole sandoz 10 mg, comprimé orodispersible | 2 | 20 | 200 | |

| Prescribed (Section Reserved For Doctor) | | 6. Medicines The Prescribing | | Section Reserved For The Pharmacist |
|--|--|---|--------|-------------------------------------|
| 2 | tramadol eg l.p. 200 mg, comprimé à libération prolongée | 10 | 10 | 100 |
| <p><u>Important:</u> The prescribing practitioner will indicate the duration of treatment for each drug, and this form is valid only for one pharmacy and its validity cannot exceed 72 hours after delivery</p> | | Total amount: | 300.00 | |
| | | To be paid by the patient (%) | 0.00 | |
| | | To be paid by MAADO | 300.00 | |
| Signature and stamp Prescribing Doctor | |  Signature and stamp Pharmacist | | |