## **Medical Care Form**

Claim number: 66666

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
	ID obligatoire							
Access To Health Care			3. Infos Reference Medical Center					
Matricule:			Date and Time:					
Nom:	ttttttt 1	ffffff 2023-07-02	Agreed healthcare network:					
Carte ID:	43234							
Full Name (first, middle, last):	tttttttt 1	ffffff 2023-07-02						
Age:	0.3		Prescribing Doctor / orientation: Krishna Singh					
Marital Status :								
Gender :	Male							
4. Details Of Medical Procedures:								
l one		ation (Medical	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: tttttttt f Carte ID: 43234  Full Name (first, middle, last):  Age: 0.3  Marital Status :  Gender : Male	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: tttttttt ffffff 2023-07-02  Carte ID: 43234  Full Name (first, middle, last):  Age: 0.3  Marital Status:  Gender: Male  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: tttttttt ffffff 2023-07-02 Agreed healthcare  Carte ID: 43234  Full Name (first, middle, last):  Age: 0.3 Prescribing Docto Krishna Singh  Marital Status:  Gender: Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: tttttttt ffffff 2023-07-02 Agreed healthcare networ  Carte ID: 43234  Full Name (first, middle, last):  Age: 0.3 Prescribing Doctor / orient Krishna Singh  Marital Status:  Gender: Male  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			. Infos Referen enter	ce Medical			
Important: The validity of this form cannot excee				exceed 5	days	from the		Tota	al amount:	
date of issue								To be paid by the patient		
Assignmeı	Assignment code								be paid by the ance company	
5. Details Of Paramedical Procedures:						ıres:				
Date Code Designation (Medical acts)			acts)		Coefficient Rate		Rate	Total Cost		
<u>Important:</u> The validity of this form cannot excee			exceed 5	days			Total amount:			
from the date of issue					To be	e paid	l by the patient			
Assignment code					To be p	paid by the insurance company				
Patient signature Signature and stamp medical H			l Heal	Signature and stamp of the Doctor						
Prescribed (Section Reserved For			The	dicines Section Reserved For The Pharmacist						
No:	Drugs		Do	sage	Quantity	Total	al Cost			
1							3201			
<u>lr</u>	<u>Important:</u> The prescribing		Tot	tal am	nount: 3201.00					

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 (%)	3136.98
		To be paid by MAADO	64.02
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist