Medical Care Form

Claim number:3ed3d3

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care		2. Patient	3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:			Agreed healthcare network:			
Carte ID:	22					
	Suyesh 15151 2023-09-02					
Age:	0.3		Prescribing Doctor / orientation:			
Marital Status :						
Gender :	Male					
edical 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 :	Access To Health Care Matricule: Nom: Suyesh Carte ID: 22 Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Suyesh 15151 2023-09-02 Agreed healthcare networ Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orient 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		3. Infos Reference Medical Center			
<u>lmportan</u>	<u>t:</u> The validit	y of this form cannot e	exceed 5 days t	from the		Tota	ıl amount:	
date of is	sue				7	o be paid by t	he patient	
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	rame	edical Procedu	ıres:	
Date	Code Designation (Medical acts)		acts)	Coefficier	nt	Rate Total Cost		
Important: The validity of this form cannot exceed			exceed 5 days			Total amount:		
from the	date of issue			To be ¡	paid	by the patient		
Assignment code				To be pai	To be paid by the insurance company			
Patient	signature	ire - I Signafiire and Stamp medical Healthcare centre I			Signature and Doctor	gnature and stamp of the octor		
Prescribe Doctor)	ed (Section R	eserved For	6. Med The Prescr	dicines ribing	or Th	Seo ne Pharmacist	ction Reserved	
No:	Dri	ugs	Dosage	Quantity T	otal	Cost		
1				2				
	•		Total am	ount: 4	0.00			
<u>I</u>	<u>mportant:</u> Th	ne prescribing						

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 (%)	26.40
		To be paid by MAADO	13.60
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist