Medical Care Form

Claim number:r34r

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
	ID obligatoire							
Access To Health Care		2. Patient	3. Infos Reference Medical Center					
Matricule:			Date and Time:					
Nom:	Lindsay	Laura 1973-02-12	Agreed healthcare network:					
Carte ID:	569161							
Full Name (first, middle, last):	Lindsay	Laura 1973-02-12						
Age:	50.7		Prescribing Doctor / orientation: Dr Amit Gulani					
Marital Status :								
Gender :	Female							
4. Details Of Medical Procedures:								
Loge	Designation (Medical acts)		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: Carte ID: Full Name (first, middle, last): Age: Age: Gender: Gender: Female Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Lindsay Laura 1973-02-12 Carte ID: 569161 Full Name (first, middle, last): Age: 50.7 Marital Status: Gender: Female edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Lindsay Laura 1973-02-12 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: 50.7 Prescribing Docto Dr Amit Gulani Marital Status : Gender : Female Posignation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Lindsay Laura 1973-02-12 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Designation (Medical Coefficient Rate			

<u>Important:</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 Referen Center	ice Medical			
Important: The validity of this form cannot exceed				exceed	5 days	from the		Tota	al amount:	
date of issue								To be paid by the patient		
Assignment code				To be pa insurance			oaid by the company			
					5. Det	ails Of P	aram	nedical Procedu	ıres:	
Date	Date Code Designation (Medical acts)			acts)		Coefficient Rate		Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed			exceed	5 days			Total amount:			
from the date of issue				To be	e paic	d by the patient				
Assignment code				To be paid by the insurance company						
Patient signature Signature and stamp medical He			cal Heal	Signature and stamp of the Doctor						
Prescribed (Section Reserved For			The	Section Reserved For The Pharmacist						
No:	Drugs D		Oosage (Quantity	Total	al Cost				
1							320			
<u>lr</u>	Important: The prescribing		 -	otal am	ount:	320.0	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 (%)	313.60
		To be paid by MAADO	6.40
Sigı	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist