## **Medical Care Form**

Claim number:sdf

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
	ID obligatoire						
Information & Access To Health Care			3. Infos Reference Medical Center				
Matricule: rimary			Date and Time:				
inom.	Laura M 20	larhysa 1978-01-	Agreed healthcare network:				
Carte ID:	594565						
		1arhysa 1978-01-					
Age:	45.8		Prescribing Doctor / orientation:				
Marital Status :							
Gender :	Female						
edical Procedures:							
Loge	Designation (Medical acts)		Coefficient	IRate	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, laura Natus):  Age:  Age:  Gender:  Gender:  Female  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  594565  Full Name (first, middle, last):  Age:  45.8  Marital Status:  Gender:  Female  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Laura Marhysa 1978-01-20  Carte ID:  594565  Full Name (first, middle, Laura Marhysa 1978-01-20  Age:  45.8  Prescribing Docto  Marital Status:  Gender:  Female  Posignation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Center  Policy  Matricule:  Date and Time:  Nom:  Laura Marhysa 1978-01-20  Carte ID:  594565  Full Name (first, middle, last):  Age:  45.8  Prescribing Doctor / orient  Marital Status:  Gender:  Female  Pesignation (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 excee				exceed	5 days	from the		Tota	al amount:	
date of issue								To be paid by the patient		
Assignment code								oaid by the company		
	5. Details Of Paramedical Procedures:						ıres:			
Date	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 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:		Dru	ugs Dosage		Oosage (	Quantity	Total	tal Cost		
1							330			
<u>Important:</u> The prescribing		1	otal am	nount: 330.00						

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 (%)	323.40	
		To be paid by MAADO	6.60	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		