Medical Care Form

Claim number:123

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:	Dhiraj G. 2000-06-18		Agreed healthcare network:				
Carte ID:	5677777						
Full Name (first, middle, last):	Dhiraj G. 2000-06-18						
Age:	23.4		Prescribing Doctor / orientation: dcds cddsdc dsc				
Marital Status :							
Gender :	Male						
edical Procedures:							
Code	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: 23.4 Marital Status: Gender: Male Male Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male Male Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: 23.4 Prescribing Doctor dcds cddsdc dsc Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly Dobligatoire		

<u>lmportant:</u> The validity of this form cannot o	Total amount:		
date of issue		To be paid by the patient	
Assignment code		To be paid by the insurance company	

Inform	nformation & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center		
lmport	ant: The validi	ty of this form cannot e	exceed 5 days	from the		Tota	ıl amount:	
date of	issue				Т	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)		Coefficie	nt	Rate	Total Cost	
Important: The validity of this form cannot exceed 5 da			exceed 5 days			Total amount:		
from th	ne date of issu	e		To be	paid	by the patient		
Assignment code			To be pa	iid by the insurance company				
Patie	ent signature	Signature and stamp medical Healthcare centre Doctor			l stamp of the			
Prescribed (Section Reserved For The			dicines	Section Reserved For The Pharmacist				
No: Dru	ıgs		Dosage	Quantity [*]	Total	Cost		
	piprazole sand odispersible	oz 10 mg, comprimé	1	1	1			
-			Total ar	nount:	1.00			
	<u>ımportant:</u> T	he 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 (%)	0.20
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.80
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist