Medical Care Form

Claim number :555555ttttt

1. Health Insurance System Information	Filling Instructions
SAM code:	Write legibly
SAM:	ID obligatoire

Information & Access To Health Care		2. Patient Policy	3. Infos Reference Medical Center
Primary insured	Matricule:		Date and Time:
	Nom:	Laura Marhysa 1978-01-20	Agreed healthcare network:
Patient	Carte ID:	594565	
	Full Name (first, middle, last):	Laura Marhysa 1978-01-20	
	Age:	45.8	Prescribing Doctor / orientation: 7777 7777 777
	Marital Status :		
	Gender :	Female	

4. Details Of Medical Procedures:

Date	Code	Designation (Medical acts)	Coefficient	Rate	Total Cost

Important: The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		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

Important: The validity of this form cannot exceed 5 days from the date of issue	Total amount:	
	To be paid by the patient	
Assignment code	To be paid by the insurance company	

5. Details Of Paramedical Procedures:

Date	Code	Designation (Medical acts)	Coefficient	Rate	Total Cost

Important: The validity of this form cannot exceed 5 days from the date of issue	Total amount:	
	To be paid by the patient	
Assignment code	To be paid by the insurance company	

Patient signature	Signature and stamp medical Healthcare centre	Signature and stamp of the Doctor

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Prescribed (Section Reserved For Doctor)	6. Medicines The Prescribing	Section Reserved For The Pharmacist

No:	Drugs	Dosage	Quantity	Total Cost
1	gabapentine ranbaxy 400 mg, gélule	2020	20	0

<table>
<tr><th colspan="3">6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)</th><th colspan="2">Section Reserved For The Pharmacist</th></tr>
<tr><td>2</td><td>gabapentine ranbaxy 400 mg, gélule</td><td>2020</td><td>20</td><td>0</td></tr>
<tr><td colspan="3" rowspan="3"><u>Important:</u> The prescribing practitioner will indicate the duration of treatment for each drug, this form is valid only for one pharmacy and its validity cannot exceed 72 hours after delivery</td><td>Total amount:</td><td>0.00</td></tr>
<tr><td>To be paid by the patient (%)</td><td>0.00</td></tr>
<tr><td>To be paid by MAADO</td><td>0.00</td></tr>
<tr><td colspan="3">Signature and stamp Prescribing Doctor</td><td colspan="2"> 
Signature and stamp Pharmacist</td></tr>
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