Medical Care Form

Claim number:

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: sourabh 2000-11-23			Agreed healthcare network:				
Carte ID:	123						
Full Name (first, middle, last):	sourabl	า 2000-11-23					
Age:	23.2		Prescribing Doctor / orientation: wef wef wef				
Marital Status :							
Gender :	Male						
4. Details Of Medical 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: sourabl Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Marital Status : Gender : Male Edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: sourabh 2000-11-23 Carte ID: 123 Full Name (first, middle, last): Age: 23.2 Marital Status: Gender: Male edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Sourabh 2000-11-23 Full Name (first, middle, last): Age: Age: 23.2 Prescribing Doctowef wef wef Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Sourabh 2000-11-23 Full Name (first, middle, last): Age: Age: 23.2 Prescribing Doctor / orient wef wef wef 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. In	fos Referend ter	ce Medica	ı		
Important: The validity of this form cannot exceed 5 days f			rom the		Tota	l amount:			
date of issue			To be paid by the			ne patient			
Assignment code				To be p insurance			aid by the company		
5. Deta			ails Of Parar	nedi	cal Procedu	res:			
Date	Code		Designation (Medical a	acts)	Coefficient	Rá	ate .	Total Cost	
Important: The validity of this form cannot exceed 5 days from the date of issue				To	tal amount:				
				To be pai	id by	the patient			
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp medical Healt			thcare centr	-	gnature and octor	stamp of	the		
,									

Prescribed Doctor)	(Section Reserved For	The	edicines	Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
1	vikas gupt	1	1	1

Prescribed (Section Reserved For Doctor)			edicines	Section Reserved For The Pharmacist
2	tomjerryhop	1	1	1
3	saurab	1	1	1
each	Important: The prescribing practitioner will indicate the duration of treatment for drug,	Total amount:		3.00
and	this form is valid only for one pharmacy	To be paid by the patient (%)		0.60
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		2.40
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		