## **Medical Care Form**

Claim number:

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			Center		al	
Matricule:			Date and Time:			
Nom:	Pranali 2000-10-11		Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Pranali 2000-10-11					
Age:	23.3		Prescribing Doctor / orientation:			
Marital Status :						
Gender :	Female					
4. Details Of Medical Procedures:						
K OUG	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: Pranali  Carte ID:  Full Name (first, middle, last):  Age: 23.3  Marital Status:  Gender: Female  edical Procedures:  Designation	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Pranali 2000-10-11  Carte ID: Full Name (first, middle, last): Age: 23.3  Marital Status: Gender: Female  edical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Pranali 2000-10-11  Agreed healthcare  Full Name (first, middle, last):  Age:  Age:  23.3  Prescribing Docto  Marital Status:  Gender:  Female  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  Pranali 2000-10-11  Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  23.3  Prescribing Doctor / orien  Marital Status:  Gender:  Female  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		Referenc	e Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Total	amount:	
date of issue					To be p	To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	ramedical I	Procedui	res:	
Date	Code	Designation (Medical acts)		Coefficier	nt Rate	Rate Total Cost		
Important: The validity of this form cannot exceed !			exceed 5 days		Total a	mount:		
from the date of issue				To be	paid by the	patient		
Assignment code				To be pai	o be paid by the insurance company			
Patient	Patient signature Signature and stamp medical Healt			Signature and stamp of the Doctor				
6. Med Prescribed (Section Reserved For The Presc Doctor)				dicines ribing	Section Reserved or The Pharmacist			
No:	Dr	ugs	Dosage(	QuantityT	otal Cost			
1		processor		0				
	•		Total am	ount: n	ull			
Important: The prescribing			-					

Prescrib 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 (%)	null
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	null
Sigi	nature and stamp Prescribing Doctor	Signat	ture and stamp Pharmacist