Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions					
SAM code:		Write legibly					
		ID obligatoire					
Information & Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:			Agreed healthcar	e networ	·k:		
Carte ID:							
Full Name (first, middle, last):							
Age:			Prescribing Docto 752 7852 782	r / orien	tation:		
Marital Status :							
Gender :							
4. Details Of Medical Procedures:							
K ode	Designa acts)	ation (Medical	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: Marital Status : Gender : edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: Designation (Medical Coefficient	Write legibly D obligatoire		

<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	

nformation & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center			
lmportant: The v	/alidit <u>y</u>	y of this form cannot e	xceed 5 days	s from the		Tota	al amount:	
date of issue						To be paid by t	he patient	
Assignment code				To be paid by the insurance company				
			5. De	tails Of P	aram	edical Procedu	ıres:	
Date Code	Code Designation (Medical acts)		acts)	Coefficie	ent	Rate Total Cost		
Important: The validity of this form cannot exceed 5			xceed 5 days	5		Total amount:		
from the date of	issue			To be	e paid	by the patient		
Assignment code				To be p	aid by	nid by the insurance company		
Patient signature Signature and stamp medical Hea			althcare co	Signature and stamp of the Doctor				
Prescribed (Sect	tion R	eserved For	The	edicines cribing	For T	Se he Pharmacist	ction Reserved	
No:	Drugs	3	Dosage	Quantity	Total	Cost		
other 3		10	10	100	00			
Important: The prescribing		Total a	mount:	ount: 100.00				

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 (%)	100.00
		To be paid by MAADO	0.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist