Medical Care Form

Claim number :wefwef

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center		al	
Matricule:		Date and Time:				
Nom:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto wef wef wef	r / orien	tation:	
Marital Status :						
Gender :						
4. Details Of Medical Procedures:						
l one	Designation (Medical acts)		Coefficient	Rate	Total Cost	
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender:	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: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Code Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: Designation (Medical Coefficient Rate	

<u>Important:</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		
<u>lmportar</u>	<u>nt:</u> The validit	y of this form cannot e	exceed 5 days	from the		Tota	al amount:
date of is	ssue				-	Го be paid by t	he patient
Assignment code				To be paid by the insurance company			
			5. Det	ails Of Pa	aram	edical Procedu	ıres:
Date	Code	Code Designation (Medical acts)		Coefficient		Rate	Total Cost
<u>lmportant:</u> The validity of this form cannot exceed !			exceed 5 days			Total amount:	
from the	date of issue			To be	paid	by the patient	
Assignmo	ent code			To be pa	aid by	the insurance company	
Patien	t signature	Signature and stamp	medical Heal	thcare ce	entre	Signature and Doctor	l stamp of the
Prescribo	ed (Section R	eserved For	6. Med The Presci	dicines ribing	For Tl	Se he Pharmacist	ction Reserved
No:	Drugs		Dosage	Quantity	Total	Cost	
1	afrom excel	1qq	1 1	l	1		
	•		Total am	ount:	1.00		
	<u>Important:</u> Th	ne 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 (%)	0.66
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.34
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist