# Medical Care Form

Claim number :234

| 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: | Prashant 1997-10-28 | Agreed healthcare network: |
| Patient | Carte ID: | 234 | |
| | Full Name (first, middle, last): | Prashant 1997-10-28 | |
| | Age: | 25.8 | Prescribing Doctor / orientation: sdf sdf sdf |
| | Marital Status : | | |
| | Gender : | Male | |

**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 |

,

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

| No: | Drugs | Dosage | Quantity | Total Cost |
|---|---|---|---|---|
| 1 | PARACETAMOL/CODEINE TEVA 500 mg/30 mg, comprimé pelliculé | 10 | 1 | 1 |

<table>
<tr><th colspan="3">Prescribed (Section Reserved For Doctor)</th><th colspan="2">6. Medicines<br>The Prescribing</th><th>Section Reserved For The Pharmacist</th></tr>
<tr><td>2</td><td colspan="2">LYRICA 300 mg, gélule</td><td>10</td><td>1</td><td>1</td></tr>
<tr><td colspan="3" rowspan="3">Important: The prescribing practitioner will indicate the duration of treatment for each drug,<br>this form is valid only for one pharmacy and its validity cannot exceed 72 hours after delivery</td><td colspan="2">Total amount:</td><td>2.00</td></tr>
<tr><td colspan="2">To be paid by the patient (%)</td><td>0.40</td></tr>
<tr><td colspan="2">To be paid by MAADO</td><td>1.60</td></tr>
<tr><td colspan="3">Signature and stamp Prescribing Doctor</td><td colspan="3">  <br>Signature and stamp Pharmacist</td></tr>
</table>