Medical Care Form

Claim number:545

SAM: ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: Patient Age: O.3 Prescribing Doctor / orientation: Marital Status: Gender: Male 4. Details Of Medical Procedures: Date and Time: Suyesh 15151 2023-09-02 Agreed healthcare network: Patient Age: O.3 Prescribing Doctor / orientation: Age: Code Designation (Medical Coefficient Rate Total	1. Health Insurance System Information			Filling Instructions				
Primary insured Matricule: Date and Time:	SAM code:			Write legibly				
Information & Access To Health Care Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Doctor / orientation: Marital Status : Gender : Male A. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total	SAM:			ID obligatoire				
Primary insured Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orientation: Marital Status: Gender: Male 4. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total	Information & Access To Health Care		2. Patient					
Nom: Suyesh 15151 2023-09-02 Agreed healthcare network: Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orientation: Marital Status : Gender : Male 4. Details Of Medical Procedures: Date Code Designation (Medical Coefficient Rate Total		Matricule:			Date and Time:			
Patient		Nom:	Suyesh 15151 2023-09-02		Agreed healthcare network:			
Patient Age: 0.3 Prescribing Doctor / orientation: Marital Status : Gender : Male 4. Details Of Medical Procedures: Date Code Designation (Medical Coefficient Rate Total		Carte ID: 22						
Marital Status : Gender : Male 4. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total			Suyesh	15151 2023-09-02				
Gender: Male 4. Details Of Medical Procedures: Date Code Designation (Medical Coefficient Rate Total	Patient	Age:	0.3		Prescribing Doctor / orientation:			
4. Details Of Medical Procedures: Designation (Medical Coefficient Rate Total		Marital Status :						
Designation (Medical Coefficient Rate Total		Gender :	Male					
iDate Kode i – Koetticient ikate i	4. Details Of M	edical Procedures:						
acts)	Date	l ode	Designation (Medical acts)		Coefficient	Rate	Total Cost	

<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. Infos Reference Medical Center		
Important: The validity of this form cannot excee			exceed 5 days 1	from the		Tota	ıl amount:	
date of iss			To	To be paid by the patient				
Assignme	nt code			To be paid by insurance compa				
			5. Det	5. Details Of Paramedical Procedures:				
Date Code Designation (Medical acts)		acts)	Coefficient Rate		Rate	Total Cost		
<u>Important:</u> The validity of this form cannot excee			exceed 5 days	5 days		「otal amount:		
from the date of issue				To be	paid b	y the patient		
Assignment code				To be pa	e paid by the insurance company			
Patient signature Signature and stamp med			o medical Heal	Signature and stamp of the Doctor			l stamp of the	
Prescribed (Section Reserved For Doctor)			6. Med The Prescr	Section Reserved For The Pharmacist				
No:	Dr	ugs	Dosage	QuantityT	otal C	ost		
1				2	250			
_	–		Total am	ount: 2	250.00			
<u>Important:</u> The 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 (%)	165.00	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	85.00	
Signature and stamp Prescribing Doctor		レ Signature and stamp Pharmacist		