Medical Care Form

Claim number:444444

| 1. Health Insurance System Information | | Filling Instructions | | | |
|--|--|---|--|---|---|
| SAM code: | | Write legibly | | | |
| SAM: | | ID obligatoire | | | |
| Information & Access To Health Care | | | 3. Infos Reference Medical Center | | |
| Matricule: | | | Date and Time: | | |
| mary ured Nom: Dhiraj G. 2000-06-18 | | 5. 2000-06-18 | Agreed healthcare network: | | |
| Carte ID: | 5677777 | | | | |
| Full Name (first, middle, last): | Dhiraj G. 2000-06-18 | | | | |
| Age: | 23.4 | | Prescribing Doctor / orientation: | | |
| Marital Status : | | | | | |
| Gender : | Male | | | | |
| edical Procedures: | | | | | |
| l oge | 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: Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male Male Code Designa | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: 5677777 Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical | Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto Marital Status: Gender: Male Designation (Medical Coefficient | Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: 2. Patient Policy Date and Time: Agreed healthcare networ Policy Agreed healthcare networ Prescribing Doctor / orien Marital Status: Gender: Male 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 | | 3. Infos Reference Medical Center | | |
|---|--|---------------|-------------------|-------------------------------------|--------------------------------------|---------------------------|--|
| | | | | | | | |
| <u>Important:</u> The validity of this form cannot exceed | | | exceed 5 days | from the | Tot | al amount: | |
| date of issue | | | | | To be paid by | To be paid by the patient | |
| Assignment code | | | | To be paid by the insurance compa | | - | |
| | | | 5. Det | ails Of Paı | ramedical Proced | ures: | |
| Date | 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 o | date of iss | sue | | To be p | oaid by the patien | t | |
| Assignment code | | | | To be paid by the insurance company | | | |
| Patient | Patient signature Signature and stamp medical Healthcare centre Doctor | | | d stamp of the | | | |
| 6. Medicines Prescribed (Section Reserved For The Prescribing Doctor) | | | | ection Reserved t | | | |
| No: | | Drugs | Dosage(| Quantity Total Cost | | | |
| 1 | | | | 40 | 0 | | |
| <u>lr</u> | <u>Important:</u> The prescribing | | Total am | ount: 40 | 0.00 | | |

| 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 (%) | 26.40 |
| | | To be paid by MAADO | 13.60 |
| Sign | nature and stamp Prescribing Doctor | Signa | ture and stamp Pharmacist |