## **Medical Care Form**

Claim number:

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:			
Nom:	Prashant 2000-10-10		Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Prashant 2000-10-10					
Age:	23.3		Prescribing Doctor / orientation: Otis MillBurn			
Marital Status :						
Gender :	Male					
4. Details Of Medical Procedures:						
Code	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: Prashar  Carte ID:  Full Name (first, middle, last):  Age: 23.3  Marital Status :  Gender : Male  edical Procedures:  Code  Designation	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Prashant 2000-10-10  Carte ID: Full Name (first, middle, last): Age: 23.3  Marital Status: Gender: Male  edical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare  Full Name (first, middle, last):  Age:  Age:  23.3  Prescribing Docto Otis MillBurn  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  Age:  23.3  Prescribing Doctor / orien Otis MillBurn  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		Infos Referen enter	ce Medical		
<u>Important</u>	:: The validit	ty of this form cannot e	exceed 5 days 1	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by th insurance compar				
			5. Det	ails Of Pa	arame	edical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coefficie	nt	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days			Total amount:		
from the o	date of issue			To be	paid	by the patient		
Assignment code				To be pa	e paid by the insurance company			
Patient signature Signature and stamp medical Heal			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The				dicines	Section Reserved			
No:	Dr	ugs	Dosage	Quantity	Total (	Cost		
1					100			
			Total am	ount: 1	100.00	)		
Important: The prescribing			-					

Prescrib each Doctor)	practitioner will 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 (%)	20.00
		To be paid by MAADO	80.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist