## **Medical Care Form**

Claim number :wefwe

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: Primary			Date and Time:			
Nom:			Agreed healthcare	e networ	·k:	
Carte ID:						
Age:			Prescribing Docto fwef 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>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		
Important: 1	The validity	y of this form cannot e	xceed 5 days	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	arame	edical Procedu	ıres:	
Date Co	Code Designation (Medical acts)		acts)	Coefficie	ent Rate To		Total Cost	
Important: The validity of this form cannot exceed			xceed 5 days			Total amount:		
from the dat	te of issue			To be	paid	by the patient		
Assignment code				To be pa	id by the insurance company			
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor					
Prescribed (Section Reserved For Th			6. Med The Presc	dicines	Section Reserved			
No:	Dru	ıgs	Dosage (	Quantity	Total	Cost		
1	000	poi	32	32	1024			
l no v	Important: The prescribing		Total am	nount: 1024.00				

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 (%)	204.80
		To be paid by MAADO	819.20
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist