## **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:			
rimary nsured 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: 23r 23r 23r			
Marital Status :						
Gender :	Male					
edical 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  Carte ID:  Full Name (first, middle, last):  Age:  23.3  Prescribing Docto 23r 23r 23r  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare netword  Carte ID:  Full Name (first, middle, last):  Age:  23.3  Prescribing Doctor / orient 23r 23r 23r  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate	

<u>Important:</u> 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. Pati Policy		3. Infos Referer Center	3. Infos Reference Medical Center	
<u>Importar</u>	<u>nt:</u> The va	lidity of this form cannot e	exceed 5 days	from the	Tota	al amount:
date of is	ssue				To be paid by t	he patient
Assignment code				To be paid by the insurance company		
			5. Det	ails Of Pa	ramedical Proced	ures:
Date	Code	Designation (Medical	Designation (Medical acts)		nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5		exceed 5 days		Total amount		
from the	date of is	ssue		To be	paid by the patient	
Assignm	ent code			To be pa	id by the insurance company	
Patien	t signatuı	re Signature and stamp	Signature and stamp medical Healthcare centre Doctor			d stamp of the
6. Medicines Prescribed (Section Reserved For  The Prescribing  Doctor)			ection Reserved t			
No: Drug	S		Dosage	Quantity	Гotal Cost	
	adol eg l. ation pro	p. 200 mg, comprimé à longée	10	100 1	1000	
			Total an	nount: 1	1000.00	
Important: 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 (%)	1000.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.00
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist