## **Medical Care Form**

Claim number:123

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: dhiraj 2001-10		001-10-10	Agreed healthcare network:		
Carte ID:	32332				
Full Name (first, middle, last):	dhiraj 2001-10-10				
Age:	22.3		Prescribing Doctor / orientation: erer sderfe rtgfre		
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: dhiraj 20  Carte ID: 32332  Full Name (first, middle, last):  Age: 22.3  Marital Status :  Gender : Male  edical Procedures:  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: dhiraj 2001-10-10  Carte ID: 32332  Full Name (first, middle, last):  Age: 22.3  Marital Status:  Gender: Male  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  dhiraj 2001-10-10  Agreed healthcare  Carte ID:  32332  Full Name (first, middle, last):  Age:  22.3  Prescribing Doctor erer sderfe rtgfre  Marital Status:  Gender:  Male  Designation (Medical  Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Date and Time:  Nom:  dhiraj 2001-10-10  Agreed healthcare network  Carte ID:  32332  Full Name (first, middle, last):  Age:  Age:  22.3  Prescribing Doctor / orienterer sderfe rtgfre  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. Pat Policy		3. Infos Refere	nce Medical Center		
<u>Important</u>	<u>::</u> The validi	ty of this form cannot	exceed 5 days	from the	To	otal amount:	
date of iss	sue				To be paid by	y the patient	
Assignment code				To be paid by the insurance company			
			5. Det	ails Of Pa	aramedical Proce	edures:	
Date	Code Designation (Medical acts)		acts)	Coefficie	nt Rate	Total Cost	
<u>Important:</u> The validity of this form cannot exceed 5			exceed 5 days		Total amou	nt:	
from the o	date of issue	9		To be	paid by the patie	ent	
Assignment code			To be paid by the insurance company				
Patient	Patient signature Signature and stamp medical Healthcare			thcare ce	Signature and stamp of the Doctor		
Prescribed (Section Reserved For The			dicines ribing	Section Reserved			
No:	Drugs		Dosage (	Quantity	Гotal Cost		
1	mayaı	mi	0 ′	l	400		
		ho muocevileire –	Total am	nount:	400.00		
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 (%)	160.00
		To be paid by MAADO	0.00
Signature and stamp Prescribing Doctor		Signa	ture and stamp Pharmacist