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:	Prashar	nt 2000-10-10	Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Prashar	nt 2000-10-10					
Age:	23.3		Prescribing Doctor / orientation: fsdf sdf sdf				
Marital Status :							
Gender :	Male						
edical Procedures:							
k ode	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status :	Access To Health Care Matricule: Nom: Prashar Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Male edical Procedures: Code Designa	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 fsdf sdf sdf sdf Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 2000-10-10 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: 23.3 Prescribing Doctor / orien fsdf sdf sdf 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	

nformation & /	formation & Access To Health Care			2. Patient Policy			3. Infos Reference Medical Center		
mportant: The	validity	y of this form cannot e	exceed 5	5 days 1	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 P	arame	edical Procedu	ıres:	
Date Code	ate Code Designation (Medical acts)				Coefficie	cient Rate		Total Cost	
Important: The validity of this form cannot exceed 5			5 days			Total amount:			
rom the date o	f issue				To be	e paid	by the patient		
Assignment code				To be p	be paid by the insurance company				
Patient signat	ture	Signature and stamp medical Healthca				entre	Signature and stamp of the Doctor		
Prescribed (Section Reserved For The			6. Med The Prescr	dicines	Section Reserved For The Pharmacist				
No: Drug	gs		Do	osage	Quantity	Total	Cost		
tomjerryhop		10) 1	0	100				
Important: The prescribing		To	otal am	ount:	100.00				

Prescrib 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 (%)	20.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	80.00
Sigı	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist