Medical Care Form

Claim number:

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care			2. Patient Policy	3. Infos Reference Medical Center			
Primary insured	Matricule:			Date and Time:			
	Nom:			Agreed healthcard	e networ	·k:	
	Carte ID:						
Patient	Full Name (first, middle, last):						
	Age:			Prescribing Doctor / orientation: we fwef wef			
	Marital Status :						
	Gender :						
4. Details Of M	edical Procedures:						
Date	Code	Designa acts)	ation (Medical	Coefficient	Rate	Total Cost	

<u>Important:</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	

Doctor) The Prescribing For The Pharmacist No: Drugs Dosage Quantity Total Cost 1 imaging 1 10 10 1000	Information & Access To Health Care				2. Patient Policy		3. Infos Reference Medical Center		
Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient									
Assignment code To be paid by the insurance company	<u>lmportan</u>	nt: The validit	y of this form cannot e	exceed 5 days	from the		Tota	al amount:	
5. Details Of Paramedical Procedures: Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient Assignment code Patient signature Signature and stamp medical Healthcare centre Company Frescribed (Section Reserved For The Pharmacist For The Pharmacist Prescribing For The Pharmacist Prescribing For The Pharmacist Imaging 1 Dosage Quantity Total Cost I imaging 1 Dosage Quantity Total Cost	date of is	sue						be paid by the patient	
Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company	Assignme	ent code							
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Prescribed (Section Reserved For The Prescribing Doctor Doctor Section Reserved For The Pharmacist Doctor Doctor Total Cost imaging 1 10 10 1000	Assignme	ent code			To be p	•			
Prescribed (Section Reserved For The Prescribing For The Pharmacist No: Drugs Dosage Quantity Total Cost 1 imaging 1 10 10 1000	Patient signature Signature and stamp me			o medical Hea	lthcare co	entre	•	l stamp of the	
1 imaging 1 10 10 1000				The		Section Reserved			
	No:	Drugs		Dosage	Quantity	Total	Cost		
T	1 imaging 1		10	10	1000				
	Important: The prescribing			Total ar	amount: 1000.00				

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 (%)	200.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	800.00
Signature and stamp Prescribing Doctor		Signa	ture and stamp Pharmacist