Medical Care Form

Claim number:99090

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:				
inom,	Laura Marhysa 1978-01- 20		Agreed healthcare network:				
Carte ID:	594565						
	Laura Marhysa 1978-01- 20						
Age:	45.8		Prescribing Doctor / orientation:				
Marital Status :							
Gender :	Female						
edical Procedures:							
l oge	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: Carte ID: Full Name (first, middle, last): Age: 45.8 Marital Status: Gender: Female edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Marital Status: Gender: Female edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctor Marital Status: Gender: Female Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Laura Marhysa 1978-01- 20 Carte ID: 594565 Full Name (first, middle, laura Marhysa 1978-01- 20 Age: 45.8 Prescribing Doctor / orien Marital Status : Gender : Female Designation (Medical Coefficient Rate		

<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	

Information & Access To Health Care			2. Patient Policy		fos Referen er	ce Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	l amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	ramedio	cal Procedu	res:	
Date	Code	de Designation (Medical acts)		Coefficie	nt Ra	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days		Tot	tal amount:		
from the o	date 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 The			6. Med The Prescr	dicines ribing	Section Reserved			
No:	Dr	ugs	Dosage	Quantity T	otal Cos	st		
1				6	78			
1.	•		Total am	nount: 678.00				
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 (%)	447.48
		To be paid by MAADO	230.52
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist