Medical Care Form

Claim number: 345356

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care		2. Patient Center Policy		e Medica	al	
Matricule:			Date and Time:			
Nom:	Dhiraj G. 2000-06-18		Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Dhiraj G. 2000-06-18					
Age:	23.4		Prescribing Doctor / orientation: Otis MillBurn			
Marital Status :						
Gender :	Male					
4. Details Of Medical 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: Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto Otis MillBurn Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: 2. Patient Policy Date and Time: Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Dhiraj G. 2000-06-18 Prescribing Doctor / orien Otis MillBurn 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	

Information & Access To Health Care			2. Patient Policy		fos Referen	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	ramedi	ical Procedu	res:	
Date	Code	ode Designation (Medical acts)		Coefficier	nt Ra	Rate Total Cost		
Important: The validity of this form cannot excee			exceed 5 days		То	tal amount:		
from the o	date of issue			To be	paid by	the patient		
Assignment code				To be pa	nid by the insurance company			
Patient signature Signature and stamp medical Hea			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The				dicines ribing	Section Reserved For The Pharmacist			
No:	Dr	ugs	Dosage	QuantityT	otal Co	st		
1		processor		0				
			Total am	ount: 0	.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 (%)	0.00
		To be paid by MAADO	0.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist