## **Medical Care Form**

Claim number:53433

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:			
Marital Status :						
Gender :	Male					
edical Procedures:						
( OUE	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  Full Name (first, middle, last):  Age:  Age:  23.4  Prescribing Docto  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 Center  Date and Time:  Agreed healthcare networ  Prescribing Doctor / orien  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		Infos Referen nter	ce Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	ıl amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by th insurance compar				
			5. Det	ails Of Pa	ırame	dical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coefficie	nt	Rate Total Cost		
Important: The validity of this form cannot exceed		exceed 5 days		7	Гotal amount:			
from the o	date of issue			To be	paid l	oy the patient		
Assignment code				To be pa	aid by the insurance company			
Patient	Patient signature Signature and stamp medical Heal			Signature and stamp of the Doctor				
Prescribed (Section Reserved For The			dicines ribing	Section Reserved For The Pharmacist				
No:	Dr	ugs	Dosage	Quantity	otal C	Cost		
1				1	1440			
_			Total am	ount: 1	1440.0	0		
Important: The prescribing			<u> </u>					

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 (%)	288.00
		To be paid by MAADO	1152.00
Sigr	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist