Medical Care Form

Claim number:

1. Health Insurance System Information		Filling Instructions					
SAM code:		Write legibly					
SAM:			ID obligatoire				
Access To Health Care			3. Infos Reference Center	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:							
l one	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: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: 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 netword Carte ID: Full Name (first, middle, last): Age: 2. Patient Policy Date and Time: Agreed healthcare netword Agreed healthcare netword Prescribing Doctor / orient Marital Status: Gender: Male 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	

mportant: 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 Patient signature Signature and stamp medical Healthcare centre Coctor 6. Medicines The Prescribing For The Pharmacist Section Reserved For The Pharmacist	nformation & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center		
Assignment code To be paid by the patient To be paid by the insurance company 5. Details Of Paramedical Procedures: Code Designation (Medical acts) Coefficient Rate Total Cost To be paid by the insurance company Total amount: To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Prescribed (Section Reserved For The Pharmacist To be paid by the insurance company Signature and stamp of the Doctor The Prescribing To The Pharmacist To Doctor To Doctor								
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Date Code Designation (Medical acts) Coefficient Rate Total Cost Date Code Designation (Medical acts) Coefficient Rate Total Cost	Assignme	nt code						
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Total amount: null	No:	Dri	ugs	Dosage(Quantity	Total	Cost	
	1				7	7326		
	•		Total am	ount: r	null			

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 (%)	null
		To be paid by MAADO	null
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist